



Arkansas **BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

**COMPREHENSIVE MAJOR MEDICAL
PREFERRED PROVIDER ORGANIZATION
GROUP BENEFIT CERTIFICATE**

Gold Plan

IMPORTANT NOTICE. Except in certain circumstances (see Section 5.0), additional costs, **including balance billing**, may be incurred for covered benefits received from a non-preferred provider. (See your schedule of benefits.) **Do not assume that a preferred provider's agreement includes all covered benefits or that all services provided a PPO Hospital are provided by preferred providers.**

Attached is the Schedule of Benefits and Identification Card indicating name, benefits, Annual Limitation on Cost Sharing amount, group number, identification number and effective date.

THIS BENEFIT CERTIFICATE CONTAINS SEVERAL SPECIFIC EXCLUSIONS. SEE SECTION 4.0

**ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. GAINES STREET
LITTLE ROCK, ARKANSAS 72201**

NOTICE OF LANGUAGE ASSISTANCE, AUXILIARY AIDS/SERVICES AND NON-DISCRIMINATION NOTICE

We provide free language assistance, appropriate auxiliary aids and services, and reasonable modifications to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call or contact Customer Service at 1-800-238-8379 (TTY:771) or Civil Rights Coordinator.

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in assessable formats are available free of charge. Call 1-800-238-8379 (TTY: 711) or speak to your provider.

Spanish: ATENCIÓN: Disponemos de servicios gratuitos de asistencia lingüística. También hay disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-238-8379 (TTY: 711) o hable con su proveedor.

Chinese Simplified: 注意：提供免费语言服务。此外，免费提供适合残障人士使用的辅助和支持服务。请致电 1-800-238-8379 (TTY: 711) 或联系您的服务提供商。

Chinese Traditional: 注意：我們提供免費的語言協助服務，以及免費的適當輔助工具和其他服務，讓您能夠獲得無障礙格式的資訊。請撥打 1-800-238-8379 (TTY: 711) 或諮詢您的服務提供者。

Tagalog: PAUNAWA: Available para sa iyo ang mga librang serbisyo sa tulong sa wika. Available rin nang walang bayad ang mga naaangkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-238-8379 (TTY: 711) o makipag-usap sa iyong provider.

French: ATTENTION : Des services d'assistance linguistique sont gratuitement mis à votre disposition. Des aides et services auxiliaires appropriés visant à vous informer dans des formats accessibles sont également mis à votre disposition gratuitement. Appelez le 1 800 238 8379 (TTY : 711) ou discutez avec votre prestataire.

Vietnamese: CHÚ Ý: Các dịch vụ hỗ trợ ngôn ngữ sẽ được cung cấp miễn phí cho quý vị. Các dịch vụ và hỗ trợ giao tiếp phù hợp nhằm cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp hoàn toàn miễn phí. Hãy gọi 1-800-238-8379 (TTY: 711) hoặc trao đổi với nhà cung cấp của quý vị.

German: HINWEIS: Ihnen stehen kostenlose Sprachmittlungsdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zum barrierefreien Zugang zu Informationen stehen ebenfalls kostenfrei zur Verfügung. Rufen Sie 1-800-238-8379 (TTY: 711) an oder sprechen Sie mit Ihrem Leistungserbringer.

Korean: 주의: 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-800-238-8379 (TTY: 711) 번으로 전화하거나 담당 서비스 제공자에게 문의하십시오.

Russian: ВНИМАНИЕ! Вам доступны бесплатные услуги языковой поддержки. Приемлемые вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-238-8379 (TTY: 711) или обратитесь к своему поставщику услуг.

Arabic: ملاحظة: خدمات المساعدة اللغوية متاحة لك مجاناً، كما أن وسائل وخدمات المساعدة الإضافية المناسبة لتوفير المعلومات بصيغ يسهل عليك الوصول إليها متاحة مجاناً أيضاً. يرجى الاتصال على الرقم: 1-800-238-8379 (TTY: 711) أو التحدث إلى مقدم الرعاية

Hindi: ध्यान दें: आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। आसान फॉर्मेट में सूचना उपलब्ध कराने के लिए उचित सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। 1-800-238-8379 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Italian: ATTENZIONE: Ha a disposizione servizi di assistenza linguistica gratuiti. Potrà usufruire gratuitamente anche di sussidi e servizi ausiliari appropriati per ottenere le informazioni in formati accessibili. Chiami il numero 1-800-238-8379 (TTY: 711) o chiedi al suo operatore sanitario.

Portuguese: ATENÇÃO: Serviços gratuitos de assistência linguística estão disponíveis para você. Ajudas e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-238-8379 (TTY: 711) ou fale com seu provedor.

French Creole: ATANSYON: Genyen sèvis asistans lang gratis disponib pou ou. Epitou, genyen lòt èd ak sèvis apwopriye disponib gratis pou ede moun jwenn enfòmasyon nan yon fòma ki aksesib. Rele 1-800-238-8379 (TTY: 711) oswa pale ak founisè w la.

Polish: UWAGA: może Pan/Pani skorzystać z bezpłatnych usług pomocy językowej. Odpowiednie dodatkowe pomoce i usługi w zakresie zapewniania dostępu do informacji w przystępnym formacie również są dostępne bezpłatnie. Prosimy dzwonić pod numer 1-800-238-8379 (TTY: 711) lub porozmawiać z lekarzem.

Japanese: 注意: 無料の言語サポートサービスをご利用いただけます。アクセシブルなフォーマットで情報を提供するための適切な援助やサービスも無料でご利用いただけます。1-800-238-8379 (TTY: 711) にお電話いただくか、医療提供者にご相談ください

NON-DISCRIMINATION NOTICE

Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex to include discrimination on the basis of sexual orientation and gender identity; sex stereotypes, sex characteristics (including intersex traits); and pregnancy or related conditions.

If you believe that we have failed to provide these language assistance or auxiliary aids and services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex to include discrimination on the basis of sexual orientation and gender identity; sex stereotypes; sex characteristic (including intersex traits); and pregnancy or related conditions, you can file a grievance with:

Civil Rights Coordinator

601 Gaines Street, Little Rock, AR 72201

Phone: 1-844-662-2276 (TTY: 711)

You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201

Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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NOTICE OF PRIVACY PRACTICES

ARKANSAS BLUE CROSS AND BLUE SHIELD

THIS NOTICE DESCRIBES HOW CLAIMS OR MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, Arkansas Blue Cross and Blue Shield is required to protect the privacy of your protected health information. We also must give you this notice to tell you how we may use and release (“disclose”) your protected health information held by Us. Arkansas Blue Cross and Blue Shield is a business name of USAble Mutual Insurance Company.

Throughout this notice, we will use the name “Arkansas Blue Cross” as a shorthand reference for Arkansas Blue Cross and Blue Shield.

Arkansas Blue Cross must use and release your protected health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative)
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected, and
- Where required by law.

Arkansas Blue Cross has the right to use and release your protected health information to evaluate and process your health plan or health insurance claims, enroll and disenroll you and your dependents, and perform related business operations.

For example:

- We can use and disclose your protected health information to pay or deny your claims, to collect your premiums, or to share your benefit payment or status with other insurer(s).
- We can use and disclose your protected health information for regular healthcare operations. Members of our staff may use information in your personal health record to assess our efficiency and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of benefits and services we provide.
- We may disclose protected health information to your employer for health plan administration purposes, including healthcare operations of the health plan, if your employer arranges for your insurance or funds the health plan coverage and serves as plan administrator. If your employer meets the requirements outlined by the privacy law to ensure adequate separation between the employer and the health plan itself, we can disclose protected health information to the appropriate health plan administrative department of your employer to assist in obtaining coverage or processing a claim or to modify benefits, work to control overall plan costs, and improve service levels. This information may be provided to the appropriate health plan administrative department of your employer in the form of routine reporting or special requests.
- We may disclose to others who are contracted to provide services as business associates on our behalf. Some services are provided in our organization through contracts with others. Examples include pharmacy management programs, dental benefits, and a copy service we use when making copies of your health record. Our contracts require these business associates to appropriately protect your information in compliance with applicable privacy and security laws.
- Our health professionals and customer service staff, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person’s involvement in your care or payment related to your care. Examples of such releases of your protected health information could include your spouse calling to verify a claim was paid, or the amount paid on a claim, or an adult child inquiring about explanation of benefit forms received by an elderly parent who is ill or impaired and unable to address their own health insurance or health plan business.

Arkansas Blue Cross may use or give out your protected health information for the following purposes, under limited circumstances:

- To state and federal agencies that have the legal right to receive Arkansas Blue Cross data (such as to make sure we are making proper claims payments)
- For public health activities (such as reporting disease outbreaks)
- For government healthcare oversight activities (such as fraud and abuse investigations)
- For judicial and administrative proceedings (such as in response to a subpoena, law enforcement agency administrative request or other court order)
- For law enforcement purposes (such as providing limited information to locate a missing person or in response to any federal or state agency administrative request that is authorized by law)
- For research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability)
- To avoid a serious and imminent threat to health or safety
- To contact you, either directly or through a business associate, using your postal or email addresses, telephone numbers or other personal information, regarding new or changed health plan benefits or new health benefits product offerings of Arkansas Blue Cross.
- To contact you, either directly or through a business associate, using your postal or email addresses, telephone numbers or other personal information, regarding health care providers participating in our networks, disease management, health education and health promotion, preventive care options, wellness programs, treatment or care coordination or case management activities of Arkansas Blue Cross.

By law, Arkansas Blue Cross must have your written permission (an “authorization”) to use or release your protected health information for any purpose other than treatment, payment or healthcare operations or other limited exceptions outlined here or in the Privacy regulation or other applicable law. Once you have given your permission for Us to release your protected health information you may take it back (“revoke”) at any time by giving written notice to Us, except if we have already acted based on your original permission. To the extent (if any) that we maintain or receive psychotherapy notes about you, most disclosures of these notes require your authorization. Also, to the extent (if any) that we use or disclose your information for our fundraising practices, we will provide you with the ability to opt out of future fundraising communications. In addition, most (but not all) uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of protected health information require your authorization.

Personal Health Record (PHR)

If you have a health benefit plan issued by Arkansas Blue Cross on or after October 1, 2007, you have a Personal Health Record (PHR). Your PHR contains a summary of claims submitted for services you received while you are or were covered by your health benefit plan, as well as non-claims data you choose to enter yourself. Your PHR will continue to exist, even if you discontinue coverage under your health benefit plan. You have access to your PHR through the Arkansas Blue Cross website. In addition, unless you limit access, your physician and other healthcare providers who provide you treatment have access to your PHR. Certain information that may exist in the claims records will not be made available to your physician and other healthcare providers automatically.

To protect your privacy, information about treatment for certain sensitive medical conditions, such as HIV/AIDS, sexually transmitted diseases, mental health, drug or alcohol abuse or family planning, will be viewable by you alone unless you choose to make this information available to the medical personnel who treat you. Similarly, non-claims data, such as your medical, family and social history, will only appear in your PHR if you choose to enter it yourself. It is important to note that you have the option to prohibit access to your PHR completely, either by electronically selecting to prohibit access or by sending a written request to prohibit access to the Privacy Office at the address below.

Special Note on Genetic Information

We are prohibited by law from collecting or using genetic information for purposes of underwriting, setting premium, determining eligibility for benefits or applying any pre-existing condition exclusion under an insurance policy or health plan. Genetic information means not only genetic tests that you have received, but also any genetic tests of your family members, or any manifestations of a disease or disorder among your family members. Except for pre-existing condition exclusions, we may obtain and use genetic

information in making a payment or denial decision, or otherwise processing a claim for benefits under your health plan or insurance policy, to the extent that genetic information is relevant to the payment or denial decision or proper processing of your claim.

Your Rights Regarding Medical Information About You

You have the right to:

- See and obtain a copy of your protected health information that is contained in a designated record set that was used to make decisions about you. This may include an electronic copy, in certain circumstances, if you make this request in writing.
- Have your protected health information amended if you believe that it is wrong, or if information is missing, and Arkansas Blue Cross agrees. If Arkansas Blue Cross disagrees, you may have a statement of your disagreement added to your protected health information.
- Receive a listing of those receiving your protected health information from Arkansas Blue Cross. The listing will not cover your protected health information that was released to you or your personal representative, or that was released for payment or healthcare operations, or that was released for law enforcement purposes.
- Ask Arkansas Blue Cross to communicate with you in a different manner or at a different place (for example, by sending your correspondence to a P.O. Box instead of your home address) if you are in danger of personal harm if the information is not kept confidential.
- Ask Arkansas Blue Cross to limit how your protected health information is used and released to pay your claims and perform healthcare operations. Please note that Arkansas Blue Cross may not be able to agree to your request.
- Get a separate paper copy of this notice.
- For purposes of obtaining our company's assistance with your application for coverage or associated subsidies through ARHOME (the federal Affordable Care Act Exchange), you have the right in so doing to request that we limit further collection, creation, disclosure, access, maintenance, storage and use of your personally identifiable information.

Breach Notification

In the event of a breach of your health information, we will provide you notification of such a breach as required by law or where we otherwise deem such notification appropriate.

To Exercise Your Rights

If you would like to contact Arkansas Blue Cross for further information regarding this notice, or exercise any of the rights described in this notice, you may do so by contacting Customer Service at the following toll-free telephone numbers:

Arkansas Blue Cross 800-238-8379

You also may access complete instructions and request forms from our companies' websites:

arkansasbluecross.com

Changes to this Notice

We are required by law to abide by the terms of this notice. We reserve the right to change this notice and make the revised or changed notice effective for claims or medical information we already have about you as well as any future information we receive. When we make changes, we will notify you by sending a revised notice to the last known address we have for you or by alternative means allowed by law or regulation. We also will post a copy of the current notice on Arkansas Blue Cross website.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Arkansas Blue Cross by writing to the following address:

Privacy Office
ATTN: Privacy Officer
P.O. Box 3216
Little Rock, AR 72201 Telephone: 866-254-4001
Email: privacyofficeinquiries@arkbluecross.com

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must:

1. be in writing;
2. contain the name of the entity against which the complaint is lodged;
3. describe the relevant problems; and
4. be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with Us.

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SCHEDULE OF BENEFITS

1.0 HOW THE COVERAGE UNDER YOUR INSURANCE PLAN WORKS

- 1.1 Your employer has established and maintains an employee health benefit plan (“Plan”) for employees and their eligible dependents. The Employer administers that Plan and actively promotes the Plan to its employees. The Employer and you, through your premium contributions, have purchased a Plan of insurance benefits provided by the Group Policy and Benefit Certificate issued by Arkansas Blue Cross and Blue Shield that provides a range of coverage for medical services you may need. This is a very valuable benefit for you, but you should understand clearly that your Plan does NOT cover all medical services, drugs, supplies, tests or equipment (“health interventions” or “interventions”). A Plan covering all health interventions would be prohibitively expensive. For that reason, we have offered, and you have purchased a more limited Plan. This document is your guide to what you have and have not purchased; in other words, what is and is not eligible for benefits under your Plan. **Accordingly, you should read this entire document carefully both now and BEFORE you obtain medical services to be sure you understand what is covered and the limitations on your coverage.**
- 1.2 The philosophy and purpose behind your Plan is that we want you to have coverage for the vast majority of medical needs or emergencies you may face, including most Hospital and Physician Services, prescription drugs, supplies and equipment. However, in order to keep costs of your Plan within reasonable limits, we have deliberately excluded coverage of a number of specific Health Interventions, we have placed coverage limits on some other interventions, and we have established an overall standard we call the “Primary Coverage Criteria” that each and every claim for benefits must meet in order to be covered under your Plan.
- 1.3 Here is an important thing for you to clearly understand. For any Health Intervention, there are six general coverage criteria that must be met in order for that intervention to qualify for coverage under your Plan.
1. The Primary Coverage Criteria must be met.
 2. The Health Intervention must conform to specific limitations stated in your Plan.
 3. The Health Intervention must not be specifically excluded under the terms of your Plan.
 4. At the time of the intervention, you must meet the Plan's eligibility standards.
 5. You must comply with the Plan's Provider network and cost sharing arrangements; and
 6. You must follow the Plan's procedures for filing claims.

The following discussion will give you a brief description of each of these qualifications.

- 1.4 **The Primary Coverage Criteria.** The Primary Coverage Criteria apply to ALL benefits you may claim under your Plan. It does not matter what types of Health Intervention may be involved or when or where you obtain the intervention. The Primary Coverage Criteria are designed to allow Plan benefits for only those Health Interventions that are proven as safe and effective treatment. The Primary Coverage Criteria also provide benefits only for the less invasive or less risky intervention when such intervention would safely and effectively treat the medical condition; or they provide benefits for treatment in an outpatient, doctor's office or home care setting when such treatment would be a safe and effective alternative to Hospitalization. Examples of the types of Health Interventions that the Primary Coverage Criteria exclude from coverage include such things as the cost of a hospitalization for a minor cold or some other condition that could be treated outside the Hospital, or the cost of some investigational drug or treatment such as herbal therapy or some forms of high dose Chemotherapy not shown to have any beneficial or curative effect on a particular cancerous condition **Finally, the Primary Coverage Criteria require that if there are two or more effective alternative Health Interventions, the Company shall limit its payment to the Allowance or Allowable Charge for the most cost-effective intervention.** The specific coverage standards that must be met under the Primary Coverage Criteria are outlined in detail in Section 2.0 of this document.
- 1.5 **Specific Limitations in Your Plan.** Because of the high cost of some Health Interventions, as well as the difficulty in some cases of determining whether an intervention is really needed, we include coverage for such Health Interventions but place limits on the extent of coverage by limiting the number of Provider visits or treatments, or treatment received during a calendar year or other specified time period. Examples of such limitations include a limit on the number of covered visits for home health services, physical, occupational and speech therapy. Other types of limitations include requirements that an intervention be provided in a particular location or by a Provider holding a particular type of license, or in accordance with a written

treatment plan or other documentation. Common benefits and limitations are outlined in detail in Section 3.0 of this document. You will note that this document refers to Coverage Policies we have developed that may address limitations of coverage for a particular service, treatment or drug. You may request a copy of our Coverage Policy with respect to a particular service, treatment or drug, or, if you have Internet access, you may review all our established Coverage Policies on our web site at WWW.ARKANSASBLUECROSS.COM

1.6 **Specific Exclusions in Your Plan.** There are many possible reasons why we have selected a particular condition, health care Provider, Health Intervention, or service to be excluded from your Plan. Some exclusions are based on the availability of other coverage or financing for certain types of injuries. For example, injuries you receive on the job are generally covered by workers' compensation. Other exclusions are based on the need to try to keep your coverage affordable, covering basic health care service needs, but not covering every possible desired intervention. The exclusion for Cosmetic Services is an example of this type of exclusion. The plan excludes coverage of some health care Providers because we believe the Provider is not qualified or because the Provider lacks experience. For example, the plan does not cover services rendered by unlicensed Providers or by Hospital residents, interns, students or fellows. Other exclusions are based on our judgment that the need for such Health Intervention is questionable in many cases, or that the services are of unknown or unproven beneficial effect. Examples of these types of exclusions include biofeedback and cranial electrotherapy stimulation devices, as well as some forms of high dose Chemotherapy and bone marrow transplantation. **Before you undergo treatment or tests, you should review the specific exclusions listed in Section 4.0 of this document. If you have any question about whether a specific exclusion applies, discuss it with your doctor(s). Call our Customer Service representatives if you need assistance.** You may also request a copy of our Coverage Policy with respect to a particular service, treatment or drug, or, if you have Internet access, you may review all our established Coverage Policies on our web site at WWW.ARKANSASBLUECROSS.COM.

1.7 **Provider Network and Cost Sharing Procedures.** Your plan does not provide coverage for a Health Intervention unless it is provided by a Provider as defined in this Plan. See Subsection 9.102.

Your plan does not provide coverage for one hundred percent of the costs associated with covered Health Interventions. You are expected to pay an initial amount of covered Allowable Charges you incur each calendar year. This amount is called a "Deductible." After you have paid the Deductible, you may pay a percentage of Allowable Charges called "Coinsurance;" In addition, for certain Health Interventions you will have to pay a fixed dollar amount called a "Copayment." Once your Deductible, Coinsurance and Copayments reach a specified amount, called an "Annual Limitation on Cost Sharing," the Company will pay one hundred percent of covered Allowable Charges you incur until the end of the calendar year.

Provider networks are designed to try to hold down the costs of your Plan through discounted medical fees that the Company has negotiated with these Providers. Your Plan includes incentives in the form of lower Deductible, lower Coinsurance and a lower Copayment to encourage you to consult and seek treatment from physicians, Hospitals and other health care Providers who participate in our Provider network, called "Preferred Providers." A full explanation of the Deductible, Coinsurance and Copayments applicable to your Plan are set out in Section 5.0 and the Schedule of Benefits.

You and your physician are always free to make any decision you believe is best for you concerning whether to receive any particular service or treatment, or whether to see any practitioner or Provider (in or out of the network). However, if you go "out-of-network" for services or treatment, your coverage will be reduced or limited to the out-of-network rate. There are exceptions to the network procedures; for example, Emergency Care or if, prior to your effective date of coverage, you were engaged with a Non-Preferred Provider for a scheduled procedure and you receive PRIOR approval from the Company to continue at the Preferred Provider benefit level for the scheduled procedure. Unless one of these exceptions applies, if you want to receive the full benefit of your Plan, you should check in advance to see if the Provider is a Preferred Provider. Preferred Providers are identified in our published Provider directory, or you may call Customer Service to ask about a specific Provider, or visit our web site at WWW.ARKANSASBLUECROSS.COM

1.8 **Eligibility Standards.** You must be eligible for benefits under your Plan at the time you receive a Health Intervention. Eligibility standards are set forth in Section 6.0 of this document. Since your coverage is through a group policy, this means you must be an eligible member of the Group, either as an Employee, or an eligible Dependent of an Employee. In order to be an eligible member of the Group, you must meet the Group eligibility standards, which may include a Waiting Period, before your Group coverage takes effect. In all

cases, in order to be considered “eligible” for coverage, your Plan must be valid and in force at the time the services or treatment are provided. All premiums must be timely paid. It is important to understand the provisions of Section 6.0 that outline the circumstances under which your coverage may terminate under the Plan. This section also describes the special situations provided by state and federal law that allow continued coverage under the Plan for a limited time after you are no longer an Employee or Dependent.

- 1.9 **Claim Filing Procedures.** Your Plan provides procedures that you, your Provider or your Authorized Representative must follow in filing claims with the Company. Your failure to follow these procedures could result in significant delays in the processing of your claim, as well as potential denial of benefits. These procedures are set out in Section 7.0. In addition, Section 7.0 explains how you can appeal a benefit determination in the event you believe that such benefit determination does not comply with the terms of the Plan. Through the appeals process, you may participate in decisions regarding your health plan coverage and communicate your preferences and point of view.
- 1.10 **Plan Administration.** Certain important matters, including financial incentives for Providers not otherwise described in this Benefit Certificate, are set out in Section 8.0. Section 9.0 is a glossary of defined terms used in the Benefit Certificate. Finally, Section 10.0 provides information the Plan is required to provide in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

2.0 PRIMARY COVERAGE CRITERIA

- 2.1 **Purpose and Effect of Primary Coverage Criteria.** The Primary Coverage Criteria are set out in this Section 2.0 of this document. The Primary Coverage Criteria are designed to allow Plan benefits for only those Interventions that are proven as safe and effective treatment. Another goal of the Primary Coverage Criteria is to provide benefits only for the less invasive or least risky Intervention when such Intervention would safely and effectively treat the medical condition, or to provide benefits for treatment in an outpatient, doctor’s office or home care setting when such treatment would be a safe and effective alternative to hospitalization. Finally, if there is more than one effective Health Intervention available, the Primary Coverage Criteria allow the Plan to limit its payment to the Allowance or Allowable Charge for the most cost-effective Intervention. Regardless of anything else in this Plan, and regardless of any other communications or materials you may receive in connection with your Plan, you will not have coverage for any service, any medication, any treatment, any procedure or any equipment, supplies or associated costs UNLESS the Primary Coverage Criteria set forth in this Section are met. At the same time, bear in mind that just because the Primary Coverage Criteria are met does not necessarily mean the treatment or services will be covered under your Plan. For example, a Health Intervention that meets the Primary Coverage Criteria will be excluded if the condition being treated is a non-covered treatment excluded by the Plan. (See Subsection 4.2.) As explained in the preceding Section 1.0, the Primary Coverage Criteria represent one category of six general coverage criteria that must be met for coverage in all cases. The Primary Coverage Criteria are as follows:
- 2.2 **Elements of the Primary Coverage Criteria.** In order to be covered, medical services, drugs, treatments, procedures, tests, equipment or supplies (“Interventions”) must be recommended by your treating physician and meet all of the following requirements:
1. The Intervention must be an item or service delivered or undertaken primarily to prevent, diagnose, detect, treat, palliate, or alleviate a medical condition or to maintain or restore functional ability of the mind or body. A “medical condition” means a disease, illness, injury, pregnancy or a biological or psychological condition that, if untreated, impairs or threatens to impair ability of the body or mind to function in a normal, healthy manner.
 2. The Intervention must be proven to be effective (as defined in Subsections 2.3.1.a. or 2.3.1.b, below) in preventing, treating, diagnosing, detecting, or palliating a medical condition.
 3. The Intervention must be the most appropriate supply or level of service, considering potential benefits and harm to the patient. The following examples illustrate application of this standard (but are not intended to limit the scope of the standard): (i) An Intervention is not appropriate, for purposes of the Primary Coverage Criteria, if it would expose the patient to more invasive procedures or greater risks when less invasive procedures or less risky Interventions would be safe and effective to prevent

diagnose, detect, treat or palliate a medical condition. (ii) An Intervention is not appropriate, under the Primary Coverage Criteria, if it involves hospitalization or other intensive treatment settings when the Intervention could be administered safely and effectively in an outpatient or other less intensive setting, such as the home.

4. The Primary Coverage Criteria allow the Plan to limit its coverage to payment of the Allowance or Allowable Charge for the most cost-effective Intervention.

“Cost-effective” means a Health Intervention where the benefits and harms relative to the costs represent an economically efficient use of resources for patients with the medical condition being treated through the Health Intervention. For example, if the benefits and risks to the patient of two alternative Interventions are comparable, a Health Intervention costing \$1,000 will be more cost effective than a Health Intervention costing \$10,000. “Cost-effective” shall not necessarily mean the lowest price.

2.3 **Primary Coverage Criteria Definitions.** The following definitions are used in describing the elements of the Primary Coverage Criteria:

1. **Effective defined**

- a. An existing Intervention (one that is commonly recognized as accepted or standard treatment or which has gained widespread, substantially unchallenged use and acceptance throughout the United States) will be deemed “effective” for purposes of the Primary Coverage Criteria if the Intervention is found to achieve its intended purpose and to prevent, cure, alleviate, or enable diagnosis or detection of a medical condition without exposing the patient to risks that outweigh the potential benefits. This determination will be based on consideration of the following factors, in descending order of priority and weight:
 - i. scientific evidence, as defined in Subsection 2.3.2, below (where available); or
 - ii. if scientific evidence is not available, expert opinion(s) (whether published or furnished by private letter or report) of an Independent Medical Reviewer(s) with education, training and experience in the relevant medical field or subject area; or
 - iii. if scientific evidence is not available, and if expert opinion is either unavailable for some reason or is substantially equally divided, professional standards, as defined and qualified in Subsection 2.3.3, below, may be consulted.
 - iv. If neither scientific evidence, expert opinion nor professional standards show that an existing Intervention will achieve its intended purpose to prevent, cure, alleviate, or enable diagnosis or detection of a medical condition, then the Company in its discretion may find that such existing Intervention is not effective and, on that basis, fails to meet the Primary Coverage Criteria.
- b. A new Intervention (one that is not commonly recognized as accepted or standard treatment or which has not gained widespread, substantially unchallenged use and acceptance throughout the United States) will be deemed “effective” for purposes of the Primary Coverage Criteria if there is scientific evidence (as defined in Subsection 2.3.2, below) showing that the Intervention will achieve its intended purpose and will prevent, cure, alleviate or enable diagnosis or detection of a medical condition without exposing the patient to risks that outweigh the potential benefits. Scientific evidence is deemed to exist to show that a new Intervention is **not** effective if the procedure is the subject of an ongoing phase I, II, or III trial or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis. If there is a lack of scientific evidence regarding a new Intervention, or if the available scientific evidence is in conflict or the subject of continuing debate, the new Intervention shall be deemed “not effective,” and therefore not covered in accordance with the Primary Coverage Criteria, with one exception -- if there is a new Intervention for which clinical trials have not been conducted because the disease at issue is rare or new or affects only a remote population, then the Intervention may be deemed “effective” if, but only if, it

meets the definition of “effective” as defined for existing Interventions in Subsection 2.3.1.a., above.

2. **Scientific Evidence defined.** “Scientific Evidence,” for purposes of the Primary Coverage Criteria, shall mean only one or more of the following listed sources of relevant clinical information and evaluation:
 - a. Results of randomized controlled clinical trials, as published in the authoritative medical and scientific literature that directly demonstrate a statistically significant positive effect of an Intervention on a medical condition. For purposes of this Subsection a., “authoritative medical and scientific literature” shall be such publications as are recognized by the Company, listed in its Coverage Policy or otherwise listed as authoritative medical and scientific literature on the Company’s web site at WWW.ARKANSASBLUECROSS.COM; or
 - b. Published reports of independent technology or pharmaceutical assessment organizations recognized as authoritative by the Company. For purposes of this Subsection b. an independent technology or pharmaceutical assessment organization shall be considered “authoritative” if it is recognized as such by the Company, listed in its Coverage Policy or otherwise listed as authoritative on the Company’s web site at WWW.ARKANSASBLUECROSS.COM.
3. **Professional Standards defined.** “Professional standards,” for purposes of applying the “effectiveness” standard of the Primary Coverage Criteria to an existing Intervention, shall mean only the published clinical standards, published guidelines or published assessments of professional accreditation or certification organizations or of such accredited national professional associations as are recognized by the Company’s Medical Director as speaking authoritatively on behalf of the licensed medical professionals participating in or represented by the associations. The Company shall have full discretion whether to accept or reject the statements of any professional association or professional accreditation or certification organization as “professional standards” for purposes of this Primary Coverage Criteria. No such statements shall be regarded as eligible to be classified as “professional standards” under the Primary Coverage Criteria unless such statements specifically address effectiveness of the Intervention, and conclude with substantial supporting evidence that the Intervention is safe, that its benefits outweigh potential risks to the patient, and that it is more likely than not to achieve its intended purpose and to prevent, cure, alleviate, or enable diagnosis or detection of a medical condition.

2.4 Application and Appeal of Primary Coverage Criteria.

1. The following rules apply to any application of the Primary Coverage Criteria. The Company shall have full discretion in applying the Primary Coverage Criteria, and in interpreting any of its terms or phrases, or the manner in which it shall apply to a given Intervention. No Intervention shall be deemed to meet the Primary Coverage Criteria unless the Intervention qualifies under ALL of the following rules:
 - a. Illegality – An Intervention does not meet the Primary Coverage Criteria if it is illegal to administer or receive it under federal laws or regulations or the law or regulations of the state where administered.
 - b. FDA Position – An Intervention does not meet the Primary Coverage Criteria if it involves any device or drug that requires approval of the U.S. Food and Drug Administration (“FDA”), and FDA approval for marketing of the drug or device for a particular medical condition has not been issued prior to your date of service. In addition, an Intervention does not meet the Primary Coverage Criteria if the FDA or the U.S. Department of Health and Human Services or any agency or division thereof, through published reports or statements, or through official announcements or press releases issued by authorized spokespersons, have concluded that the Intervention or a means or method of administering it is unsafe, unethical or contrary to federal laws or regulations. Neither FDA Pre-Market Approval nor FDA finding of substantial equivalency under 510(k) automatically guarantees coverage of a drug or device.

- c. Proper License – An Intervention does not meet the Primary Coverage Criteria if the health care professional or facility administering it does not hold the proper license, permit, accreditation or other regulatory approval required under applicable laws or regulations in order to administer the Intervention.
 - d. Plan Exclusions, Limitations or Eligibility Standards – Even if an Intervention otherwise meets the Primary Coverage Criteria, it is not covered under this Plan if the Intervention is subject to a Plan exclusion or limitation, or if you fail to meet Plan eligibility requirements.
 - e. Position Statements of Professional Organizations – Regardless of whether an Intervention meets some of the other requirements of the Primary Coverage Criteria, the Intervention shall not be covered under the Plan if any national professional association, any accrediting or certification organization, any widely-used medical compendium, or published guidelines of any national or international workgroup of scientific or medical experts have classified such Intervention or its means or method of administration as “experimental” or “investigational” or as questionable or of unknown benefit. However, an Intervention that fails to meet other requirements of the Primary Coverage Criteria shall not be covered under the Plan, even if any of the foregoing organizations or groups classify the Intervention as not “experimental” or not “investigational,” or conclude that it is beneficial or no longer subject to question. For purposes of this Subsection e., “national professional association” or “accrediting or certifying organization,” or “national or international workgroup of scientific or medical experts” shall be such organizations or groups recognized by the Company, listed in its Coverage Policy or otherwise listed as authoritative on the Company’s web site at WWW.ARKANSASBLUECROSS.COM.
 - f. Coverage Policy – With respect to certain drugs, treatments, services, tests, equipment or supplies, the Company has developed specific Coverage Policies, which have been put into writing, and are published on the Company’s web site at WWW.ARKANSASBLUECROSS.COM. If the Company has developed a specific Coverage Policy that applies to the drug, treatment, service, test, equipment or supply that you received or seek to have covered under your Plan, the Coverage Policy shall be deemed to be determinative in evaluating whether such drug, treatment, service, test, equipment or supply meets the Primary Coverage Criteria; **however, the absence of a specific Coverage Policy with respect to any particular drug, treatment, service, test, equipment or supply shall not be construed to mean that such drug, treatment, service, test, equipment or supply meets the Primary Coverage Criteria.**
 - g. The plan uses InterQual to review certain services for medical necessity as provided for under the Coverage Policy. InterQual is evidence-based criteria that offers guidance in covering medical and behavioral health for all levels of care in addition to care planning, complex care management, durable medical equipment, procedures, and specialty pharmacy. An Intervention does not meet Primary Coverage Criteria where there is an absence or insufficient evidence supporting clinical effectiveness and safety of a drug, device, or service under review unless otherwise required by state or federal law.
2. You may appeal a determination by the Company that an Intervention does not meet the Primary Coverage Criteria to the Appeals Coordinator. Use the procedures for appeals outlined in Sections 7.2 and 7.3.
 3. Any appeal available with respect to a Primary Coverage Criteria determination shall be subject to the terms, conditions and definitions set forth in the Primary Coverage Criteria. An appeal shall also be subject to the terms, conditions and definitions set forth elsewhere in this Plan. The Appeals Coordinator or an External Review organization shall render its independent evaluation so as to comply with and achieve the intended purpose of the Primary Coverage Criteria and other provisions of this Plan.

3.0 BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN

Because of the high cost of some services or treatments, as well as the difficulty in some cases of determining whether services are really needed, we include coverage for such services or treatments but place limits on the extent of

coverage, by limiting the number of Provider visits or treatments during a calendar year or other specified period of time. This Section 3.0 describes medical services, drugs, supplies, tests and equipment for which coverage is provided under the Plan, provided all terms, conditions, exclusions and limitations of the Plan, including the six coverage criteria, are satisfied. This Section 3.0 sets out specific limitations applicable to each covered medical service, drug, supply, test or equipment.

You will note references to Deductible, Coinsurance and Copayment obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network Provider or an Out-of-Network Provider, refer to Section 5.0, the definition of Allowance or Allowable Charge as set out in the Glossary of Terms and the Schedule of Benefits.

3.1 Professional Services. Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, coverage is provided for the following professional services when performed by a Physician. All Covered Services are subject to the applicable Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.

1. **Primary Care Physician Office Visits.** Coverage is provided for the diagnosis and treatment of illness or Injury when provided in the medical office of your Primary Care Physician. The Covered Person is responsible for the Copayment, Deductible and Coinsurance specified in the Schedule of Benefits.

You are encouraged to select and maintain a patient-physician relationship with a PCP. A PCP can be helpful to you in managing your health care. The PCP selected must be an In-network Physician listed in the Preferred Provider Directory as a PCP and must be accepting new patients. You may contact Customer Service to select a PCP or change your PCP

2. **Specialty Care Physician Office Visits.** Coverage is provided for the diagnosis and treatment of illness or Injury when provided in the medical office of the Specialty Care Physician. The Covered Person is responsible for the Copayment, Deductible and Coinsurance specified in the Schedule of Benefits.

3. **Physician Hospital Visits.** Coverage is provided for services of Physicians for diagnosis, treatment and consultation while the Covered Person is admitted as an inpatient in a Hospital for Covered Services.

4. **Surgical Services.** Coverage is provided for services of Physicians for surgery, either as an inpatient or outpatient,. If coverage is provided for two (2) or more surgical operations performed during the same surgical encounter or for bilateral procedures, payment for the secondary or subsequent procedure will be made at a reduced rate. In general, overall payment for one or more procedures during the same operative setting will be no more than if the procedures had been done by one Physician. Details as to how such payments are calculated are provided to In-Network Physicians through *Provider News* and Coverage Policy.

5. **Telephone and Other Electronic Consultation.** Subject to all other terms, conditions, exclusions, and limitations of this Plan set forth in this Benefit Certificate.

i. Coverage is provided for Telemedicine services performed by a Provider licensed, certified, or otherwise authorized by the laws of Arkansas to administer health care in the ordinary course of the practice of his or her profession at the same rate as if it had been performed in-person provided the Telemedicine service is comparable to the same service provided in person.

ii. However, electronic consultations such as, but not limited to, telephonic, interactive audio, fax, text messaging, email, or for services, which are, by their nature, hands-on (e.g., surgery, interventional radiology, coronary, angiography, anesthesia, and endoscopy) are not covered. Audio-only communication is covered if it is real-time, interactive and substantially meets the requirements for a Covered Service that would otherwise be covered by the Plan.

iii. Communications made by a Physician responsible for the direct care of a Covered Person in Case Management with involved health care Providers, or consultative electronic

communication between a Primary Care Physician and other health care Providers regarding a Covered Person's care, however, are covered.

6. **Assistant Surgeon Services.** Not all surgeries merit coverage for an assistant surgeon. Further, the Company's payment for a covered assistant surgeon shall be limited to one Physician qualified to act as an assistant for the surgical procedure. Surgical first assistants are not covered (See Section 4.1.10).
7. **Standby Physicians.** Services of standby physicians are only covered in the event such physician is required to assist with certain high-risk services specified by the Company, and only for such time as such physician is in immediate proximity to the patient.
8. **Abortions.** Abortions are not covered, see Subsection 4.2.1. Pregnancy terminations under the direction of a Physician are covered, but only when performed in an In-Network Hospital or Outpatient Hospital setting.

3.2 **Preventive Health Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, the Company will pay one hundred percent (100%) of the Allowance or Allowable Charges for the routine preventive health services listed below when provided by a an In-Network Primary Care Physician or an advanced practice nurse or physician's assistant who provides primary medical care in the areas of general practice, pediatrics, family practice, internal medicine or obstetrics/gynecology, which are performed in the Primary Care Physician's office. When the service cannot be performed in an office by a Primary Care Physician, coverage is also provided for certain preventive health services listed below when performed in an In-Network Outpatient Hospital or Ambulatory Surgery Center, unless otherwise provided below.

1. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force but not for the related treatment of disease; and
2. routine immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
3. with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this subsection; and
5. the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention, unless state law provides a greater benefit; and
6. with respect to prostate cancer screenings for men, one screening per year for a man forty (40) years of age or older in accordance with the National Comprehensive Cancer Network guidelines; and as in effect on January 1, 2023¹; and
7. an in-home health evaluation once per year.

3.3 **Hospital Services.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, including applicable Deductible, Copayment and Coinsurance specified in the Schedule of Benefits, coverage is provided for the following Hospital services. All Hospital services must be performed or prescribed by a Physician and provided by a Hospital.

1. **Inpatient Hospital Services.** This benefit is subject to the following specific limitations and notification to the Company prior to non-emergency Inpatient Hospital services:
 - a. Inpatient Hospitalization requires a patient to receive Covered Services 24 hours a day as

an inpatient in a Hospital.

- b. All Hospital admissions, including admissions to a Long-Term Acute Care facility, are subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, including Coverage Policy terms as applicable
- c. Payment for Hospital charges for inpatient admissions shall be limited to the lesser of the billed charge or the Allowance or Allowable Charge established by the Company.
- d. If you have a condition requiring that you be isolated from other patients, the Company will pay for an isolation unit equipped and staffed as such.
- e. In the event services are rendered for a covered benefit during an inpatient admission to a Hospital where the admitting diagnosis was for a non-covered benefit, the Company will pay that portion of the Hospital charge which is attributable to services rendered for the covered benefit.
- f. The services of social workers shall be included in the basic daily room and board allowance.
- g. Services rendered in a Hospital in a country outside of the United States of America shall not be paid except at the sole discretion of the Company.

2. **Outpatient Hospital Services.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, including Coverage Policy terms as applicable coverage is provided for services, including but not limited to chemotherapy and renal dialysis, in an Outpatient Hospital, Outpatient Surgery Center or Outpatient Radiation Therapy Center.

- a. If you use an out of state Outpatient Surgery Center that does not contract with the local Blue Cross and Blue Shield Plan, payment for all such services, including Professional Services, will be limited to the Allowance or Allowable Charge for all the services or \$500 whichever is less. See Subsection 3.4.

3. **Hospital Services in Connection with Dental Treatment.** Coverage is provided for Hospital services, including anesthesia, services in connection with treatment for a complex dental condition provided to: (i) a Covered Person who is determined by two (2) dentists (in separate practices) to require the dental treatment without delay; (ii) a Covered Person with a diagnosis of serious mental or physical condition; or (iii) a Covered Person, certified by his or her Primary Care Physician to have a significant behavioral problem.

3.4 **Ambulatory Surgery Center.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate and subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits, and subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, as well as Coverage Policy terms as applicable, coverage is provided for specific surgical services received at an Ambulatory Surgery Center that are performed or prescribed by a Physician.

- 1. Covered services include diagnostic imaging and laboratory services required to augment a surgical service and performed on the same day as such surgical service.
- 2. Ambulatory Surgery Center services in connection with treatment for a complex dental condition are provided in accordance with Subsection 3.3.3.
- 3. **If you use an out of state Ambulatory Surgery Center that does not contract with the local Blue Cross and Blue Shield Plan, payment for all such services, including Professional Services, will be limited to the Allowance or Allowable Charge incurred for all the services or \$500, whichever is less.**

3.5 **Outpatient Diagnostic Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for diagnostic services and materials, including but not limited to, diagnostic imaging (e.g. x-rays, fluoroscopy, ultrasounds, radionuclide studies) electrocardiograms, electroencephalograms and laboratory tests when performed or prescribed by a Physician and subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.

3.6 **Advanced Diagnostic Imaging Services.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, as well as Coverage Policy terms as applicable, coverage is provided for and subject to the Deductible and Coinsurance specified in the Schedule of Benefits, computed tomography scanning (“CT SCAN”), Magnetic Resonance Angiography or Imaging (“MRI/MRA”), Nuclear Cardiology and positron emission tomography scans (“PET SCAN”) (collectively referred to as “Advanced Diagnostic Imaging”). PET Scans are covered to diagnose or screen for cancer in Covered Persons who have been previously diagnosed with cancer, subject to the terms, conditions, exclusions and limitations set forth in Coverage Policy.

3.7 **Maternity.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for Maternity Care when performed or prescribed by a Physician subject to the Deductible, Copayment and Coinsurance amounts specified in the Schedule of Benefits.

1. **Maternity and Obstetrical Care.**

- a. Coverage is provided for Maternity and Obstetrical Care, including Routine Prenatal Care and postnatal care; and use of Hospital delivery rooms and related facilities; special procedures as may be necessary. Coverage includes screening the birth mother for depression within the first six (6) weeks of birth, not subject to the Deductible or Copayment.
- b. Routine Prenatal Care includes the coverage of one routine ultrasound only. See Subsection 4.2.97 concerning exclusion of additional routine ultrasounds.
- c. **Notification.** Coverage for Maternity and Obstetrical Care requires the Covered Person or the Covered Person’s treating Provider to notify the Company of a pregnancy. You are encouraged to notify the Company within the first trimester.

2. **Midwives.** Services provided by any lay midwife are not covered. See Subsection 4.1.4. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for services provided by a certified nurse midwife who has a collaborative agreement with a Physician who is within immediate proximity to the Hospital utilized by the certified nurse midwife in case there is need for assistance during the delivery.

3. **Newborn Care in the Hospital.** Provided the Child’s coverage becomes effective on his or her date of birth in accordance with the provisions of Section 6.0, coverage is provided for a Hospital stay for the mother and newborn child of at least forty-eight (48) hours following a vaginal delivery or at least ninety-six (96) hours following a cesarean section, unless the treating provider, after consulting with the mother, discharges the mother or newborn child earlier. Hospital stays lasting more than either forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section require Prior Approval from the Company. An Employee’s or Spouse’s newborn Child will be covered from the date of birth, including use of newborn nursery (for up to five (5) days or until the mother is discharged, whichever is the lesser period of time) and related services. However, if such Child is born in an Out-of-Network Hospital, the Child’s coverage for Out-of-Network services in the first 90 days is limited to the Allowance or Allowable Charges incurred or \$2,000, whichever is less. For more information on how Prior Approval works and its potential effect on coverage of benefits, see Subsection 7.1.3.b. and the definition of Prior Approval in Subsection 9.99.

If a Child is born in an Out-of-Network Hospital because the Employee’s Spouse has other coverage, or if such Child is an adopted child born in an Out-of-Network Hospital, nursery charges are covered up to the Allowance or Allowable Charge incurred or \$2,000, whichever is less.

4. **Family Planning Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for the following family planning services when authorized and provided by In-Network Physicians:

- a. Counseling and planning services for Infertility;
- b. Pregnancy terminations under the direction of a Physician are covered, but only when performed in an In-Network Hospital or In-Network Outpatient Hospital setting. Abortion is not covered. See Subsection 4.2.1;

- c. Contraceptives are covered under Subsections 3.2 – Preventive Health Services and 3.25 - Medications;
- d. Voluntary sterilizations (vasectomies and tubal ligations). Reversal of a voluntary sterilization is not covered.

5. **Allowable Charges for Infertility Testing, Artificial Insemination. In Vitro Fertilization and Cryopreservation.** Subject to all terms, conditions, exclusions, and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for Allowable Charges for the above-referenced services when the criteria, as defined in the applicable Coverage Policy, is established and the services are provided by an In-Network Provider.

- a. **Infertility Diagnostic Testing.** Coverage is provided for certain diagnostic testing of a Covered Person, as set out in the Coverage Policy, to establish or confirm a diagnosis of infertility.
- b. **Artificial Insemination.** Coverage is provided for artificial insemination when the Covered Person has a medically documented inability to conceive due to a diagnosis of infertility listed in the Coverage Policy.

Coverage is provided for no more than six cycles.

- c. **In-vitro Fertilization.** Coverage is provided for in-vitro fertilization when the criteria, as defined in the applicable Coverage Policy, is established. The Covered Person's oocytes must be fertilized with the sperm of the Covered Person's Spouse unless the reason for infertility is related to the absence of sperm in the Spouse or the absence of oocytes in the Covered Person, or the presence of unviable sperm in the Spouse or unviable oocytes in the Covered Person.

The in-vitro fertilization procedure must be performed by a Board-Certified Reproductive Endocrinology and Infertility Physician Specialist in order to be eligible for benefits. The in-vitro fertilization benefit is limited to four complete oocyte retrievals per lifetime of the member or two live births from separate pregnancies as a result of the in vitro fertilization procedures. After a first live birth is achieved as a result of a successful in vitro fertilization cycle, up to two additional complete oocyte retrievals may be covered. All viable embryos, fresh or frozen, must be used before undergoing additional oocyte retrieval.

- d. **Exclusions of Infertility and In-Vitro Fertilization Coverage.** Benefits for infertility diagnostic testing, artificial insemination and in-vitro fertilization are not available if:
 - i. the Covered Person or his or her Spouse has previously had a voluntary sterilization; or
 - ii. the infertility is related to natural age-related hormone reduction (i.e., postmenopausal or 45 years of age or older); or
 - iii. a surrogate is used; or
 - iv. one of the Covered Persons has previously had three live births by any means.
- e. **Cryopreservation.** Coverage is provided for cryopreservation of oocytes and embryos from covered member or spouse as long as this policy is in effect (see applicable coverage policy).
- f. No benefits are available for post-coital testing of cervical mucus, screening for anti-sperm antibodies, hamster testing, sperm penetration assay, assisted hatching, co-culture of embryos, cryopreservation of ovarian tissue, cryopreservation of testicular tissues in prepubertal boys, or for storage or thawing of ovarian tissue, or testicular tissue.

3.8 **Rehabilitation and Habilitation Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, and any applicable Coverage Policy coverage is provided for Rehabilitation and Habilitation when performed or prescribed by an In-Network Physician and performed in an In-Network facility. Such therapy and developmental services include physical and occupational therapy as well as services provided for developmental delay, developmental speech or language disorder,

developmental coordination disorder and mixed developmental disorder. Therapy must be performed by an appropriate registered physical, occupational or speech-language therapist licensed by the appropriate State Licensing Board and must be furnished in accordance with a written treatment Plan established and certified by the treating Physician. Developmental Services must be provided by a provider licensed by the state or certified by an organization approved by the Company and must be furnished in accordance with a written treatment plan established and certified by the treating Physician. This benefit is subject to the Copayment and/or Deductible and Coinsurance specified in the Schedule of Benefits.

1. **Rehabilitation Services**

- a. **Inpatient Therapy.** Coverage is provided for inpatient therapy services, including professional services, when performed or prescribed by a Physician and rendered in a Hospital. Inpatient stays for therapy are limited to sixty (60) days per Covered Person per calendar year.
- b. **Outpatient Therapy.** Coverage is provided for outpatient therapy services when performed or prescribed by a Physician. Coverage for outpatient visits for physical therapy, occupational therapy, speech therapy and chiropractic services is limited to an aggregate maximum of thirty (30) visits per Covered Person per calendar year. Coverage for physical, occupational and speech therapy is subject to the Primary Care Physician copayment as listed in the Schedule of Benefits. Coverage for chiropractic services is subject to the Specialty Care Physician benefit listed in the Schedule of Benefits. See Subsection 9.80 - Outpatient Therapy Visit.
- c. **Cardiac and Pulmonary Rehabilitation Therapy.** Coverage for cardiac and pulmonary rehabilitation therapy is provided in accordance with Coverage Policy. Coverage for cardiac rehabilitation therapy limited to a maximum of 36 visits per Covered Person per calendar year. However, coverage is not provided for cardiac or pulmonary rehabilitation therapy from Freestanding Facilities. Peripheral vascular disease rehabilitation therapy is not covered. See Subsection 4.2.78.
- d. **Cognitive Rehabilitation.** Cognitive Rehabilitation is generally not covered. See Subsections 4.2.15 and 9.15.
- e. **Radio-Frequency Thermal Therapy.** The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered. See Subsection 4.2.80. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage for radio-frequency thermal therapy is provided and included in the payment for the primary procedure of the orthopedic condition.

2. **Habilitation Services**

- a. **Outpatient Therapy.** Coverage is provided for outpatient therapy services when performed or prescribed by a Physician. Coverage for outpatient visits for physical therapy, occupational therapy, speech therapy and chiropractic services is limited to an aggregate maximum of thirty (30) visits per Covered Person per calendar year. Coverage for physical, occupational and speech therapy is subject to the Primary Care Physician copayment as listed in the Schedule of Benefits. Coverage for chiropractic services is subject to the Specialty Care Physician benefit listed in the Schedule of Benefits. See Subsection 9.80 - Outpatient Therapy Visit.
- b. **Developmental Services.** Coverage is provided for Developmental Services when performed or prescribed by a Physician and is limited to a maximum of 180 Developmental Services Visit per Covered Person per calendar year. See Subsection 9.29 - Developmental Service Visit.
- c. **Durable Medical Equipment.** Durable Medical Equipment required for Habilitation is covered in accordance with Subsection 3.12.

3.09 **Mental Illness and Substance Use Disorder.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate as well as the Deductible, Copayment and Coinsurance set out

in the Schedule of Benefits, coverage is provided for Health Interventions to treat Mental Illness and Substance Use Disorder.

1. **Inpatient, Partial Hospitalization Program and Intensive Outpatient Program Health Interventions.** Coverage for Inpatient Hospitalization, Partial Hospitalization Programs or Intensive Outpatient Programs for Mental Illness or Substance Use Disorder Health Interventions is subject to the following requirements and prior notification to the Company prior to non-emergency Inpatient Hospital services.
 - a. Inpatient Hospitalization requires a patient to receive Covered Services 24 hours a day as an inpatient in a Hospital.
 - b. Partial Hospitalization Programs generally require the patient to receive Covered Services six to eight hours a day, five to seven days per week in a Facility.
 - c. Intensive Outpatient Programs generally require the patient to receive Covered Services lasting two to four hours a day, three to five days per week in a Facility.
2. **Non-Hospital Health Interventions.**
 - a. Office Visits. Coverage is provided for a Health Intervention provided during an office visit with a Psychiatrist, Psychologist or other Provider licensed to provide treatment for Mental Illness or Substance Use Disorder.
 - b. Residential Treatment Facilities. Coverage is provided for a maximum of 60 days per Covered Person per calendar year for Health Interventions at a Residential Treatment Facility for Mental Illness or Substance Use Disorder.
 - i. The facility is licensed by the State of Arkansas or the appropriate agency in the state where the facility is located.
 - ii. The facility is accredited by The Joint Commission (TJC) or the Commission on Accreditation of Rehabilitation Facilities (CARF International).
 - iii. Coverage is provided for a maximum of 60 days per Covered Person per calendar year. The 60-day maximum limitation for Residential Treatment Facilities applies to all three services listed below whether it is one service or a combination of services.
 - (1.) Residential Treatment Programs - Covered Person sleeps in the facility engaging in 6 to 8 hours of a multidisciplinary treatment program.
 - (2.) Partial Day Rehabilitation- Covered Person sleeps elsewhere- 6 hours of multidisciplinary treatment program minimum of 5 days a week.
 - (3.) Intensive Outpatient Rehabilitation- Covered Person sleeps elsewhere - 3 hours of multidisciplinary treatment program 5 days a week.
 - iv. The services must be of a temporary nature and required to increase ability to function.
 - v. Custodial care is not covered.
3. Coverage for counseling or treatment of marriage, family or child relationship dysfunction is only covered if the dysfunction is due to a condition defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
4. Hypnotherapy is not covered for any diagnosis or medical condition. See Subsection 4.2.50.
5. Repetitive Transcranial Magnetic Stimulation Treatment (rTMS). Coverage is provided for repetitive transcranial magnetic stimulation treatment (rTMS) to treat refractory depression subject to Coverage Policy.

3.10 **Autism Spectrum Disorder Benefits.** Subject to all other terms, conditions, exclusions, and limitations of the Plan as set forth in the Coverage Policy as well as the Deductible, Copayment, and Coinsurance set out in the Schedule of Benefits, coverage is provided for:

1. Covered Persons with autism spectrum disorder.
2. Therapeutic Care as defined in Section 9.120 that is Habilitative in nature is not subject to the Habilitative treatment limitations as specified in the Summary of Benefits and Coverage Policy.
2. Applied behavioral analysis as specified in Coverage Policy is provided per Covered person with autism spectrum disorder when ordered by a Physician or a psychologist for the Covered Person when medically necessary under the direction of a Board-Certified Behavioral Analyst (BCBA):
4. Pharmaceutical care as defined in Section 9.83;
5. Health Interventions to treat Mental Illness or Substance Use Disorder as specified in Section 3.09 where the health interventions relate to a diagnosis of autism spectrum disorder and
6. Equipment determined medically necessary to provide evidence-based treatment of an autism spectrum disorder.

Any care for an individual with autism spectrum disorder that is ordered by a Physician must be medically necessary and evidenced-based as specified in the Coverage Policy. Coverage provided for autism spectrum disorder is not subject to any limits on the number of visits an individual may have to an autism service provider.

3.11 **Emergency Care Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for Emergency Care. When Emergency Care is needed the Covered Person should seek care at the nearest facility. Emergency Care received within forty-eight (48) hours of the emergency is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits. If the Covered Person is admitted as an inpatient to the same Hospital where Emergency Care was rendered, the Emergency Care Copayment is waived, and all services are subject to the inpatient Deductible, Copayment and Coinsurance.

1. **After-Hours Clinic or Urgent Care Center.** Services provided in an after-hours or urgent care center are subject to the Urgent Care Center Deductible, Copayment and Coinsurance for each visit.
2. **Observation Services.** Observation services are covered when ordered by a Physician. Observation Services ordered in conjunction with an emergency room visit or outpatient visit are subject to the Emergency Care Deductible, Copayment and Coinsurance for each visit.
3. **Transfer to In-Network Hospital.** Continuing or follow-up treatment for Injury or Emergency Care is limited to care that meets Primary Coverage Criteria before you can be safely transferred, without medically harmful or injurious consequences, to an In-Network Hospital. Services are subject to all applicable Deductible, Copayment and Coinsurance.
4. **Hospital Admissions.** A Hospital admission subsequent to Emergency Care services requires the Covered Person or the Covered Person's treating Provider to notify the Company of an emergency admission to a Hospital within 24 hours or the next business day. **PLEASE NOTE: This does not guarantee payment or assure coverage. All Health Interventions must still meet all other coverage terms, conditions, and limitations. Coverage for services may still be limited or denied if, when the claims are received by Us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the claim and the actual Health Intervention, that the Covered Person ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Benefit Certificate.**
5. **Medical Review of Emergency Care.** Emergency Care is subject to medical review. If, based upon the signs and symptoms presented at the time of treatment as documented by attending health care personnel, the Company determines that a visit to the emergency room fails to meet the definition of Emergency Care as set out in this Benefit Certificate (See Subsection 9.38 - Emergency Care), coverage shall be denied, and the emergency room charges will become the Covered Person's liability.
6. **Allowable Charge.** If You need Emergency Care, the Company will cover You at the highest Allowance or Allowable Charge that federal regulations allow. You will have to pay any charges that

exceed the Allowance or Allowable Charge as well as for any Deductibles, Coinsurance, Copayments and amounts that exceed any benefit maximums.

3.12 **Durable Medical Equipment.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for Durable Medical Equipment (DME) when prescribed by an In-Network Physician according to the guidelines specified below. This benefit, together with the benefit for equipment under Subsection 3.19, Home Health Services, is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.

1. Durable Medical Equipment is equipment which (1) can withstand repeated use; and (2) is primarily and customarily used to serve a medical purpose; and (3) generally is not useful to a person in the absence of an illness or injury; and (4) is appropriate for use in the home. Coverage for Durable Medical Equipment and Medical Supplies is provided when the Durable Medical Equipment is provided in accordance with Coverage Policy. Examples of Durable Medical Equipment include, but are not limited to, oxygen equipment, wheelchairs and crutches.
2. Durable Medical Equipment delivery or set up charges are included in the Allowance or Allowable Charge for the Durable Medical Equipment.
3. For adults, a single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery is covered. (See Section 3.30 - Pediatric Vision Services for coverage of lenses for children.) With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. The Allowance or Allowable Charge is based on the cost for basic glasses or contact lenses. Eyeglass frames are subject to a \$65 maximum Allowance or Allowable Charge.
4. Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Covered Person.
5. When it is more cost effective, the Company in its discretion will purchase rather than lease equipment. In making such purchase, the Company may deduct previous rental payments from its purchase Allowance.
6. Coverage for Medical Supplies used in connection with Durable Medical Equipment is limited to a 90-day supply per purchase.
7. Wound Vacuum Assisted Closure (VAC) Wound VAC devices are not covered without meeting Coverage Policy.

3.13 **Medical Supplies.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, Medical Supplies (See Subsection 9.66), other than Medical Supplies that can be purchased without a prescription, are covered when prescribed by a Physician.

1. Expenses for Medical Supplies provided in a Physician's office are included in the reimbursement for the procedure or service for which the supplies are used.
2. Coverage for Medical Supplies is limited to a 90-day supply per purchase.
3. Coverage for Medical Supplies used in connection with Durable Medical Equipment, Subsection 3.12, is subject to the Deductible, Coinsurance and Copayment specified in the Schedule of Benefits.
4. Expenses for Medical Supplies provided in connection with home infusion therapy are included in the reimbursement for the procedure or service for which the supplies are used.

3.14 **Prosthetic and Orthotic Devices and Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, and subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits, coverage is provided for non-dental Prosthetic and Orthotic Devices, including associated services, and its repair if such device is required for treatment of a condition arising from an illness or Accidental Injury. Prosthetic Devices do not include dentures or other dental appliances that replace either teeth or structures directly supporting the teeth. The Company will provide you the Allowance or Allowable Charge for a Prosthetic Device. Replacement of a Prosthetic or Orthotic Device is covered no more frequently than once per three-year period except when necessitated by normal growth or when the

age of the Prosthetic or Orthotic Device exceeds the device's useful life. Maintenance and repair resulting from misuse or abuse of a Prosthetic or Orthotic Device are the responsibility of the Covered Person.

Prosthetic Devices to assist hearing or talking devices are not generally covered. See Subsection 4.2.44. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for:

1. cochlear implant (an implantable hearing device inserted into the modiolus of the cochlea and into cranial bone) and its associated speech processor up to a lifetime maximum benefit of one cochlear implant per ear, per Covered Person unless replacement is necessitated because there is inadequate response to existing component(s) that interfere with the Covered Person's activities of daily living or one or more components are no longer functional and cannot be repaired; and
2. one auditory brain stem implant per lifetime for an individual twelve years of age and older with a diagnosis of Neurofibromatosis Type II (NF2) who has undergone or is undergoing removal of bilateral acoustic tumors; and
3. surgically implantable osseointegrated hearing aid for patients with single-sided deafness and normal hearing in the other ear. Coverage is further limited to Covered Persons with
 - a. congenital or surgically induced malformations (e.g., atresia) of the external ear canal or middle ear;
 - b. chronic external otitis or otitis media;
 - c. tumors of the external canal and/or tympanic cavity; and
 - d. sudden, permanent, unilateral hearing loss due to trauma, idiopathic sudden hearing loss, or auditory nerve tumor.

3.15 **Diabetes Management Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, the Company will cover up to 10 hours for initial instruction of a Diabetes Self-Management Training and an additional 2 hours annually (calendar year). Such training program must be in compliance with the national standards for diabetes self-management education programs developed by the American Diabetes Association. If there is significant change in the Covered Person's symptoms or conditions which make it necessary to change the Covered Person's diabetic management process, the Company will pay for an additional Diabetes Self-Management Training Program. This benefit is payable for training in or out of the Hospital that has been prescribed by a Physician.

Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, the Plan will cover an eye examination to screen for diabetic retinopathy once per calendar year for Covered Persons who are diagnosed with diabetes.

The Company will pay for Durable Medical Equipment, Medical Supplies and services for the treatment of diabetes.

3.16 **Podiatric Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for routine foot care to treat podiatric conditions associated with metabolic (e.g. diabetes, gout, etc.), neurologic (peripheral neuropathy of any etiology), and peripheral vascular disease. In the absence of a systemic condition, treatment of mycotic nails may be covered once every 60 days unless medical documentation supports the need for more visits, when the following criteria are met.

1. **Ambulatory Covered Person**
 - a. There is clinical evidence of mycosis of the toenail, and
 - b. The Covered Person has marked a limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.
2. **Non-ambulatory Covered Person**
 - a. There is clinical evidence of mycosis of the toenail, and
 - b. The Covered Person suffers from pain or secondary infection resulting from the thickening

and dystrophy of the infected toenail plate.

3.17 **Ambulance Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate and applicable Coverage Policies, coverage is provided as follows. The coverage for Ambulance Services is subject to the Copayment, Deductible and Coinsurance specified in the Schedule of Benefits.

1. Benefits for Ambulance Services to treat a Covered Person in place if the Ambulance Service is coordinating care through Telemedicine with a Physician for medical-based complaint or behavioral health Provider for behavioral-based complaint; or triage and transport a Covered Person to an Alternative Destination if the Ambulance Service is coordinating care through Telemedicine with a Physician for medical-based complaint or a behavioral health Provider for behavioral-based complaint; Ambulance Services only include transportation to the treatment location where the initiation of the service is the result of a 911 call as documented in the records of the Ambulance Service;
2. Benefits for ground Ambulance Services for local transportation to the nearest Hospital in the event Emergency Care is needed; (See Subsection 9.33 Emergency Care.) or to the nearest neonatal special care unit for newborn infants for treatment of Accidental Injuries, illnesses, congenital birth defects or complication of premature birth that require that level of care.
3. Benefits for air Ambulance Services are limited to: a.) the Covered Person possessing unstable vital signs including respiratory status or cardiac status including conditions as defined within the Coverage Policy; b.) services requested by police or medical authorities at the scene of an Accidental Injury or illness; c.) Those situations in which the Covered Person is in a location that cannot be reached by ground ambulance due to weather or road conditions; or d.) transportation by ground ambulance poses a threat to the Covered Person's survival or seriously endangers the Covered Person's health due to the time or distance.
4. Non-emergent medical transportation. Non-emergent Ambulance Services are not covered.
5. Specific Ambulance Service Exclusions. No benefits will be paid for: 1.) Expenses incurred for Ambulance Services covered by a local governmental or municipal body, unless otherwise required by law; 2.) Non-emergency ambulance; 3.) Air ambulance: a.) outside the 50 United States and the District of Columbia; b.) From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or c.) From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States; 3.) Ambulance Services provided for comfort or convenience for a Covered Person, their family, caregiver, Provider or any facility. ; or 4.) Non-emergency transportation excluding ambulances.

3.18 **Skilled Nursing Facility Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for Skilled Nursing Facility services when authorized in advance by a Physician. See Subsection 9.112 for the definition of Skilled Nursing Facility. This benefit is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits. This Skilled Nursing Facility services benefit is subject to the following conditions:

1. The admission must be within seven days of release from an inpatient Hospital stay;
2. The Skilled Nursing Facility services are of a temporary nature and increase ability to function;
3. Custodial Care is not covered (See Subsections 4.3.7 and 9.26);
4. Coverage is provided for a maximum of sixty (60) days per Covered Person per calendar year.

3.19 **Home Health Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, including but not limited to the exclusion of Custodial Care (see Subsections 4.3.7 and 9.26), coverage is provided for Home Health Services when Coverage Policy supports the need for in-home service and such care is prescribed or ordered by a Physician. This Home Health Services benefit is subject to the following conditions:

1. Covered Services must be provided through and billed by a licensed home health agency.

2. Covered Services provided in the home include services of a Registered Professional Nurse (R.N.), a Licensed Practical Nurse (L.P.N.) or a Licensed Psychiatric Technical Nurse (L.P.T.N.), provided the nurse is not related to you by blood or marriage or does not ordinarily reside in your home.
 3. Home Health visits are subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.
 4. Coverage is provided for a maximum of fifty (50) visits per Covered Person per calendar year. (Home infusion services are not covered by this Section 3.20 but are covered under Subsection 3.24.1.d.).
- 3.20 **Hospice Care.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, if the Covered Person has been diagnosed and certified by the attending Physician as having a terminal illness with a life expectancy of six months or less, the Company will pay the Allowance or Allowable Charge for Hospice Care. The services must be rendered by an entity licensed by the Arkansas Department of Health or other appropriate state licensing agency and accepted by the Company as a Provider. This benefit is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.
- 3.21 **Dental Care Services.** Dental Care, oral surgery, orthodontic services and Prosthodontic Services are generally not covered. However subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for certain limited and specific conditions as set forth below in the subsections under this section 3.22. Such coverage, if any, is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits and as stated in this Benefit Certificate, all services are subject to Primary Coverage Criteria.
1. Any Health Intervention related to dental caries or tooth decay is not covered
 2. Benefits for oral surgery. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, the Company will pay only for the following non-dental oral surgical procedures:
 - a. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required. Periapical lesions are not covered;
 - b. Surgical procedures required to treat an acute Accidental Injury (See Subsection 9.1 Accidental Injury) to jaws, cheeks, lips, tongue, roof and floor of the mouth. The Covered Person must seek treatment within 7 days of the Accidental Injury for services to be covered. Coverage will not be continued past twelve (12) months of the first date of treatment for the Accidental Injury unless continuous and systematic treatment of the Accidental Injury is still ongoing.
 - c. Excision of exostoses of jaws and hard palate;
 - d. Extra-oral incision and drainage of abscess; and
 - e. Incision of accessory sinuses, salivary glands or ducts.
 3. Benefits for Accidental Injury. If a Covered Person has an Accidental Injury, benefits will be provided, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, for Dental Care and x-rays necessary to correct damage to a Non-Diseased Tooth or surrounding tissue caused by the Accidental Injury. The Covered Person must seek treatment within 7 days of Accidental Injury for services to be covered. Coverage will not be continued past twelve (12) months of the first date of treatment for the Accidental Injury unless continuous and systematic treatment of the Accidental Injury is still ongoing.
 - a. Only the Non-Diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-Diseased Tooth or Teeth immediately adjacent will be considered for replacement
 - b. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.

- c. Injury to a tooth or teeth while eating is not considered an Accidental Injury; treatment of such injury will not be covered;
 - d. Any Health Intervention related to dental caries or tooth decay is not covered.
4. Dental services in connection with other Covered Services.
- a. Dental services for treatment directly related to radiation treatment of a head or neck malignancy are covered.
 - b. Dental services, not to include reconstruction or implants, performed at the dental infection site when perioperative to organ transplant because infection precludes listing for a transplant, are covered;
 - c. Dental services, not to include reconstruction or implants, performed at the dental infection site when perioperative to hematopoietic stem cell transplant because infection precludes listing for a transplant, are covered; and
 - d. Dental services, not to include reconstruction or implants, performed at the dental infection site when perioperative to valve replacement or surgery because infection precludes surgery, are covered.
5. Benefits for anesthesia services. Hospital and Ambulatory Surgery Center services and anesthesia services related to dental procedures, including services to children, are covered in accordance with Subsection 3.3.3.
6. Benefits for dental reconstructive surgery. Coverage is provided for the surgery performed on a Child for the correction of cleft palate or lip when prescribed or ordered by an In-Network Physician. Coverage is provided for surgery and orthodontics performed on a Child for the correction of a cleft palate when prescribed or ordered by an In-Network Physician. See Subsection 3.23.3 below for coverage of corrective surgery and related Health Interventions for a Covered Person who is diagnosed as having a craniofacial anomaly.
7. Benefits for Prosthodontic Services. Prosthodontic Services generally are not covered. Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate including the Deductible and Coinsurance set out in the Schedule of Benefits, and subject to Primary Coverage Criteria that applies to all services, the only coverage is provided for Prosthodontic Services are services which meet the criteria provided in this Section 3.22. Prosthodontic Services are not covered when such services are due, in whole or in part, to neglect or the unintended consequence of a felonious activity, regardless of whether there has been an arrest, any criminal charges or any court findings of a felony, as long as the activity meets the definition of a felony under Arkansas law. Replacement of teeth that have been absent for a period of five years or more also are not covered. If payable, all Prosthodontic Services are subject to the Allowance or Allowable Charge.

3.22 Reconstructive Surgery. Cosmetic Services are not covered. (See Subsections 4.3.5 and 9.21) Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, and subject to the Copayment, Deductible and Coinsurance specified in the Schedule of Benefits, coverage is provided for the following reconstructive surgery procedures when prescribed or ordered by an In-Network Physician:

- 1. Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Covered Person. The Covered Person must seek treatment within 7 days of Accidental Injury for services to be covered. Coverage will not be continued past twelve (12) months of the first date of treatment for the Accidental Injury unless continuous and systematic treatment of the Accidental Injury is still ongoing.
- 2. Surgery performed for removal of a port-wine stain or hemangioma (on the head, neck, or face).
- 3. Treatment provided for reconstructive surgery following neoplastic (cancer) surgery.
- 4. In connection with a mastectomy resulting from surgery, services for (a) reconstruction of the breast on which the surgery was performed; (b) surgery to reconstruct the other breast to produce a

symmetrical appearance; and (c) prostheses and services to correct physical complications for all stages of the mastectomy, including lymphedemas.

5. Reduction mammoplasty, if such reduction mammoplasty meets Coverage Criteria is covered. .
6. Gender Reassignment Surgery for Gender Dysphoria. Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, , coverage is provided for gender reassignment surgery for Covered Persons meeting diagnostic criteria and therapeutic Provider criteria as specified in Coverage Policy.
7. Dental services are **not** covered under this Subsection. See Subsection 3.21 - Dental Care, above.

3.23 **Craniofacial Anomaly Services** Coverage is provided for related Health Interventions for a Covered Person who is diagnosed as having a craniofacial anomaly provided the Health Interventions meet Primary Coverage Criteria to improve a functional impairment that results from the craniofacial anomaly as determined by a nationally accredited cleft-craniofacial team, approved by the American Cleft Palate-Craniofacial Association in Chapel Hill, North Carolina. A nationally accredited cleft-craniofacial team for cleft-craniofacial conditions shall evaluate Covered Persons with craniofacial anomalies and coordinate a treatment plan for each Covered Person. Coverage includes corrective surgery as provided below, dental care, and vision care for the following will be provided if the Health intervention meets Primary Coverage Criteria.

1. On an annual basis: Sclera contact lenses, including coatings; an ocular impression of each eye; and any additional tests or procedures related to treatment of the craniofacial anomaly as specified in the approved treatment plan developed by the nationally accredited cleft-craniofacial team;
2. Every two years, two hearing aid molds, and a choice of two wearable bone conduction, two surgically implantable bone-anchored hearing aids or two cochlear implants;
3. Every four years, a dehumidifier and
4. Covered Persons will be charged the In-Network Deductible and Coinsurance for any provider outside the state of Arkansas. **NOTE: Any out of state Provider that has not entered into a contract with Arkansas Blue Cross and Blue Shield is not bound to accept a payment made by Arkansas Blue Cross and Blue Shield in addition to the Covered Person's In-Network Deductible and Coinsurance as payment in full. Any Out-of-Network Provider, including Out-of-Network Providers outside the state of Arkansas, may choose to seek additional remuneration or fees from a Covered Person. Selection of an out of state Out-of-Network Provider is solely made at the risk of the Covered Person.**
5. Coverage is provided for corrective surgery and related Health Interventions for a Covered Person who is diagnosed as having a craniofacial anomaly provided the Health Interventions meet Primary Coverage Criteria to improve a functional impairment that results from the craniofacial anomaly as determined by a surgical member of a nationally accredited cleft-craniofacial team, approved by the American Cleft Palate-Craniofacial Association in Chapel Hill, North Carolina. A nationally accredited cleft-craniofacial team for cleft-craniofacial conditions shall evaluate Covered Persons with craniofacial anomalies and coordinate a treatment plan for each Covered Person.

3.24 **Medications.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, coverage is provided for Prescription Medication. (See Subsection 9.97 - Prescription Medication.) This coverage varies, depending upon the sites of service where the Medication is received by the Covered Person.

1. **Sites of Service**
 - a. **Hospital or Ambulatory Surgical Center.** The benefit for Medications received from a Hospital or an Ambulatory Surgical Center is included in the Allowance or Allowable Charge for the Hospital or Ambulatory Surgical Center services. See Subsections 3.3 and 3.4.
 - b. **Physician's Office.** The benefit for Medications administered in a Physician's office is covered based upon the Allowance or Allowable Charge for the Medication and subject to the Deductible, Coinsurance and Copayment specified in the Schedule of Benefits.

Conditions of coverage set forth in Subsections 3.24.2.a, b., and c., are applicable to this coverage.

- c. **Retail Pharmacy (Drug Store).** The benefit for Medications received from a licensed retail pharmacy is covered based upon the Allowable Charge for the Medication and subject to the applicable Prescription Drug Copayment specified in the Schedule of Benefits.
- i. **Covered Medications.** Generally, only A Medications are covered under this Subsection 3.24.1.c. however, a limited number of B Medications are covered under this Subsection 3.24.1.c. B Medications are covered under Subsections 3.24.1.a, b., and d. (See Subsection 9.97 for definitions of “A Medications” and “B Medications.”)
 - ii. **Administration Charges.** Charges to administer or inject any Medication are not covered under this Subsection 3.24.1.c.
 - iii. **Conditions of Coverage.** Conditions of coverage set forth in Subsections 3.24.2.a., b., c., d., and e., are applicable to this coverage.
 - iv. **ID Card Presentation.** In order to receive benefits for a Prescription Medication under this Subsection 3.24.1.c., a Covered Person must present his or her Arkansas Blue Cross and Blue Shield ID card to a Participating Pharmacy at the time the Covered Person purchases the Prescription Medication. (“Participating Pharmacy” is defined in Subsection 9.82.) The pharmacist will electronically notify the Company’s prescription benefits processor. The prescription benefits processor will electronically inform the pharmacist whether the Plan provides benefits for the Prescription Medication. If the prescription benefits processor indicates that the Plan does not provide benefits, the Covered Person may call the Pharmacy Help Line telephone number on the back of his or her ID card. If the Plan provides benefits, the pharmacist will charge the Covered Person the applicable Copayment for the Prescription Medication. Applicable Prescription Copayments are listed in Schedule of Benefits. The Company will only accept a post-purchase or paper claim for Prescription Medications purchased through a retail pharmacy (drug store) if such claim is submitted (1) for an Emergency Prescription, (See Subsection 9.33.), (2) for Prescription Medication purchased prior to the date the Covered Person received his or her Arkansas Blue Cross and Blue Shield ID card or (3) in accordance with Subsection 3.24.1.c.v., below.
 - v. **Claim Submission.** The presentation of a Prescription to a pharmacist in accordance with this Subsection 3.24.1.c., is not a claim for benefits under the terms of the Plan. However, a Covered Person may submit a claim if, upon such a presentation, the pharmacist informs the Covered Person that, because of the provisions of the Plan, the Plan has rejected benefits for the requested Prescription Medication.
 - vi. **Non-Participating Pharmacies.** Medications purchased from a non-Participating Pharmacy, except in an emergency situation, are not covered.
 - vii. **Emergency.** When a Covered Person receives a Prescription Medication in connection with Emergency Care as defined in this Benefit Certificate (See Subsection 9.38) and is unable to obtain the Medication from a Participating Pharmacy, the Covered Person should purchase the Medication at the nearest pharmacy and submit a prescription claim form for reimbursement. The claim payment will be limited to the Allowable Charge, less the applicable Prescription Copayment.
 - viii. **Medical Supplies.** Medical supplies such as, but not limited to, colostomy supplies, bandages and similar items are not generally covered under this Subsection 3.24.1.c; however, refer to Subsections 3.13 Medical Supplies and Subsection 3.24.1.d., below. Furthermore, subject to the terms, conditions, exclusions and

limitations of the Plan as set forth in this Benefit Certificate, coverage is provided under this Subsection 3.24.1.c., for insulin and syringes purchased at the same time as insulin and which are to be used for the sole purpose of injecting insulin. Syringes not meeting this standard are not covered. In addition, certain blood glucose test meter supplies such as test strips and lancets are covered under the pharmacy benefit.

- ix. **Immunizations.** Immunization agents and vaccines identified as preventive care vaccines for adults and children, see Subsection 3.2., are covered when obtained at a retail pharmacy.
- x. **Durable Medical Equipment.** Durable Medical Equipment, even though such device may require a prescription, such as, but not limited to, therapeutic devices, artificial appliances, blood glucose test meters, or similar devices, are not covered under this Subsection 3.24.1.c. Refer to Subsection 3.12 - Durable Medical Equipment. However, certain blood glucose test meter supplies, such as test strips and lancets, are covered under the pharmacy benefit.
- xi. **Prescriptions, Excluded Providers.** Prescriptions ordered or written by any Physician or Provider who is excluded from coverage under the Plan, are not covered. Prescriptions presented to or filled by any Pharmacy which is excluded from coverage under the Plan, are not covered. See Subsection 4.1.
- xii. **Copayment Information**

Each Prescription is covered only after the Covered Person pays the applicable Copayment (listed on the Covered Person's Schedule of Benefits) to the Participating Pharmacy. Covered Persons will be charged the appropriate Copayment for each Prescription or refill. An initial fill of a Maintenance Medication Prescription is covered for one month only. A refilled Maintenance Medication Prescription may be covered for up to a 3-month supply with one Copayment applied for each month's supply. (See Subsection 9.61 - Maintenance Medication.)

When a Generic Medication is dispensed, the Covered Person will pay the Generic Medication Copayment specified in the Schedule of Benefits for each initial and refill Prescription. If there is no generic equivalent, the Covered Person will pay the Brand Name Medication Prescription Drug Copayment for each initial and refill Prescription.

If a Brand Name Medication is dispensed when a Generic Medication is available, the Covered Person will pay the Prescription Drug Copayment plus the difference in the cost of the Brand Name Medication and Generic Medication, or the cost of the medication, whichever is less.

- d. **Home Infusion Therapy Pharmacy.** The benefit for Medications received from a licensed retail pharmacy designated by the Company as a home infusion therapy Provider is covered based upon the Allowance or Allowable Charge for the Medication.
 - i. **Covered Medications.** A Medications and B Medications are covered under this Subsection 3.24.1.d. (See Subsection 9.97 for definitions of "A Medications" and "B Medications.") A Medications are covered subject to the Prescription Medication Copayment as listed in the Schedule of Benefits. B Medications are covered subject to the calendar year Deductible and Coinsurance listed in the Schedule of Benefits.
 - ii. FDA approved medications that exist as separate components and are intended for reconstitution prior to administration are covered. Examples include, but are not limited to, total parental, intravenous antibiotics and hydration therapy.
 - iii. **Conditions of Coverage.** Conditions of coverage set forth in Subsections 3.24.2. a., b., c., d., and e., are applicable to this coverage.

- iv. **Medical Supplies.** Medical Supplies used in connection with home infusion therapy are covered under this Subsection 3.24.1.d. See Subsection 3.13.
- v. **Administration Charges.** Charges to administer or inject Medication by a licensed medical professional operating under his/her scope of practice are covered under this Subsection 3.24.1.d., according to the allowable fee schedule for skilled nursing under both home infusion therapy and Home Health.

2. **Conditions of Coverage**

- a. **Prior Approval.** Selected Prescription Medications, as designated from time to time by the Company, are subject to Prior Approval through criteria established by the Company as detailed in Coverage Policy before coverage is allowed. A list of Medications for which Prior Approval is required is available from the Company upon request or, if you have Internet access, you may review this list on the Company's web site at WWW.ARKANSASBLUECROSS.COM. This Subsection 3.24.2.a., is applicable to Prescription Medication covered by Subsections 3.24.1.b., c., and d.
- b. **Specialty Medications.** Selected Prescription Medications are designated by the Company as "Specialty Medications" due to their route of administration, approved indication, unique nature, or inordinate cost. These medications usually require defined handling and home storage demands, crucial patient education, and careful monitoring. Such medications include, but are not limited to growth hormones, blood modifiers, immunoglobulins, and medications for the treatment of hemophilia, deep vein thrombosis, hepatitis C, Crohn's disease, cystic fibrosis, multiple sclerosis and rheumatoid arthritis. Specialty Medications may be A Medications or B Medications. Coverage for Specialty Medications is subject to Prior Approval and may only be purchased through a specialty pharmacy vendor under contract with the Company. The benefit for a Specialty Medication is subject to the calendar year Deductible and Coinsurance specified in the Schedule of Benefits. A list of Specialty Medications is available from the Company upon request or, if you have Internet access, you may review this list on the Company's web site at WWW.ARKANSASBLUECROSS.COM. This Subsection 3.24.2.b., is applicable to Prescription Medication covered by Subsections 3.24.1.b., c., and d.
- c. **Formulary.** Except in limited circumstances set out in this Subsection 3.24.2.c., and elsewhere in this Benefit Certificate, a Prescription Medication must be listed in the Formulary in order to be covered. (See Subsection 9.42 Formulary.)
 - i. A list of Medications on the Formulary is available from the Company upon request or, if you have Internet access, you may review this list on the Company's web site at WWW.ARKANSASBLUECROSS.COM.
 - ii. If a Prescription Medication in the Formulary causes or has caused adverse or harmful reactions for a particular Covered Person, or has been shown to be ineffective in the treatment of a Covered Person's particular disease or condition, such Covered Person may be able to obtain coverage for a Prescription Medication not in the Formulary by requesting Prior Approval from Arkansas Blue Cross and Blue Shield, Managed Pharmacy, FAX (501) 378-6980, or mailed to Post Office Box 2181, Little Rock, Arkansas 72203. Alternatively, you may e-mail your request to APPEALSCOORDINATOR@ARKBLUECROSS.COM.
 - 1. **Standard Exception Request.** If the Company is able to process your request without requesting additional information (see Subsection 7.1.4.), it will notify you of its determination within 72 hours from the date it received the exception request or, in the event additional information is necessary, within 72 hours of receipt of the additional information. Any standard exception request for a Prescription Medication not in the Formulary will be approved for the duration of the prescription, including refills.

2. Exception Request under Exigent Circumstances. An exception request for a Prescription Medication not in the Formulary will be considered in the event a Covered Person is suffering from a health condition that may seriously jeopardize the Covered Person's life, health, or ability to regain maximum function or when a Covered Person is undergoing a current course of treatment using a Prescription Medication not in the Formulary. If the Company is able to process your request without requesting additional information (see Subsection 7.1.4.), it will notify you of its determination within 24 hours from the date it received the request, or, in the event additional information is necessary, within 24 hours of receipt of the additional information. Any exception request under exigent circumstances is approved for the duration of the exigency.
 3. External Review of Denied Exception. If your request for either a standard exception to the Formulary or for an exception under exigent circumstances is denied, you may request an external review by an Independent Review Organization (see Subsection 7.3.). This request may be made through Arkansas Insurance Commissioner, 1 Commerce Way, Suite 102, Little Rock, Arkansas 72202 or by calling (800)852-5494. A determination will be made on your appeal within 72 hours for a standard exception request or within 24 hours for an exception request under exigent circumstances. (See Subsection 7.3.11. regarding Notification of Determination.)
- d. **Step Therapy.** Selected Prescription Medications as designated from time to time by the Company in its discretion are subject to Step Therapy restrictions. (See Subsection 9.115 - Step Therapy.) Such Step Therapy must be completed before coverage for the selected Prescription Medication is provided. The Step Therapy requirements for a particular Prescription Medication are available from the Company upon request. This Subsection 3.24.2.d., is applicable to Prescription Medication covered by Subsections 3.24.1.c., and d.
1. Standard Exception Request. If the Company is able to process your request without requesting additional information (see Subsection 7.1.4.), it will notify you of its determination within 72 hours from the date it received the exception request or, in the event additional information is necessary, within 72 hours of receipt of the additional information. Any standard exception request for a Prescription Medication subject to Step Therapy will be approved for the duration of the prescription, including refills.
 2. Exception Request under Exigent Circumstances. An exception request for a Prescription Medication subject to Step Therapy will be considered in the event a Covered Person is suffering from a health condition that may seriously jeopardize the Covered Person's life, health, or ability to regain maximum function or when a Covered Person is undergoing a current course of treatment using a Prescription Medication subject to Step Therapy. If the Company is able to process your request without requesting additional information (see Subsection 7.1.4.), it will notify you of its determination within 24 hours from the date it received the request, or, in the event additional information is necessary, within 24 hours of receipt of the additional information. Any exception request under exigent circumstances is approved for the duration of the exigency.
 3. External Review of Denied Exception. If your request for either a standard exception to the Formulary or for an exception under exigent circumstances is denied, you may request an external review by an Independent Review Organization (see Subsection 7.3.). This request may be made through Arkansas Insurance Commissioner, 1 Commerce Way, Suite 102, Little Rock, Arkansas 72202 or by calling (800) 852-5494. A determination will be made on your appeal within 72 hours for a standard

exception request or within 24 hours for an exception request under exigent circumstances. (See Subsection 7.3.11. regarding Notification of Determination.)

e. **Dispensing Quantities - Limitations**

A Prescription Medication will not be covered for any quantity or period in excess of that authorized by the prescribing Physician or health care Provider.

Early refills are covered at the discretion of the Company. A prescription will not be covered if refilled after one year from the original date of the prescription.

Coverage of selected Prescription Medications as designated from time to time by the Company in its discretion is subject to Dose Limitations. (See Subsection 9.32 - Dose Limitation.) The Dose Limitation for a particular Prescription Medication is available from the Company upon request.

This Subsection 3.24.2.e., is applicable to Prescription Medication covered by Subsections 3.24.1. d.

3.25 **Organ Transplant Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for human-to-human organ or tissue transplants in accordance with the following specific conditions:

1. Not all transplants are covered. There must be a specific Coverage Policy which allows benefits for the transplant in question, and the Covered Person must meet all of the required criteria necessary for coverage set forth in the Coverage Policy and in this Benefit Certificate.
2. The transplant benefit is subject to the Deductible and Coinsurance specified in the Schedule of Benefits.
3. Notwithstanding any other provisions of this Benefit Certificate, at the option of the Company, the Allowance or Allowable Charge for an organ transplant, including any charge for the procurement of the organ, Hospital services, Physician Services and associated costs, including costs of complications arising from the original procedure that occur within the Transplant Global Period, shall be limited to the lesser of (a) ninety percent (90%) of the billed charges or (b) the global payment determined as payment in full by a Blue Cross and Blue Shield Association Blue Distinction Centers for Transplant participating facility, if the Covered Person chooses to use that facility. If the Covered Person receives the transplant from a facility outside of Arkansas that is not in the Blue Distinction Centers for Transplant network but is contracted with a local Blue Cross and/or Blue Shield Plan, the Allowable Charge shall be the price contracted by such Blue Cross and/or Blue Shield Plan. (See Section 7.1.10 Out-of-Arkansas Services). If the Covered Person receives the transplant from a facility that is not in the Blue Distinction Centers for Transplant network and does not contract with the local Blue Cross and/or Blue Shield plan, the Allowance or Allowable Charge for the transplant services provided in the Transplant Global Period is eighty (80%) percent of an amount equaling the lesser of (a) ninety (90%) percent of billed charges or (b) the average allowable charge authorized by participating facilities in the Blue Distinction Centers for Transplant network located in the geographic region where the transplant is performed. **Please note that our payments for any transplant (whether performed within the transplant network or by a non-participating facility) are limited to a global payment that applies to all covered transplant services; we will not pay any amounts in excess of the global payment for services the facility or any physician or other health care Provider or supplier may bill or attempt to bill separately, because the global payment is deemed to include payment for all related necessary services (other than non-covered services). If you use a facility participating in the Blue Distinction Centers for Transplant network, that facility has agreed to accept the global payment as payment in full and should not bill you for any excess amount above the global payment, except for applicable Deductible, Coinsurance or non-covered services; however, a non-participating facility may bill you for all amounts it may charge above the global payment. These charges above the global payment could amount to thousands of dollars in additional out of pocket expenses to you.**

4. When the Covered Person is the potential transplant recipient, a living donor's Hospital costs for the removal of the organ are covered with the following limitations:
 - a. Allowance or Allowable Charges are only covered for the period beginning on the day before the transplant to the date of discharge or 39 days, whichever is less.
 - b. Donor testing is covered only if the tested donor is found compatible.
 5. Solid organ transplants of any kind are not covered for individuals with a malignancy that is presently active or in partial remission (e.g., non-metastatic resectable squamous and basal cell carcinoma of the skin are excepted.). A solid organ transplant of any kind is not covered for a Covered Person that has had a malignancy removed or treated in the 3 years prior to the proposed transplant. For purposes of this section, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma or melanoma, and breast. The only exception to this non-coverage is for solid organ transplant for hepatocellular carcinoma under certain circumstances, as outlined in the Coverage Policy for hepatocellular carcinoma.
 6. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to the Company's specific Coverage Policies relative to these specific conditions.
- 3.26 **Medical Disorder Requiring Specialized Nutrients or Formulas.** Subject to all terms, conditions, exclusions, and limitations of the Plan as set forth in this Benefit Certificate, any Deductible, Copayment, and Coinsurance specified in the Schedule of Benefits, coverage is provided for Medical Foods and Low Protein Modified Food Products, amino-acid-based elemental formulas, extensively hydrolyzed protein formulas, formulas with modified vitamin or mineral content and modified nutrient content formulas for the treatment of a Covered Person diagnosed with a Medical Disorder Requiring Specialized Nutrients or Formulas if
1. the Medical Foods and Low Protein Modified Food Products shall only be administered under the direction of a clinical geneticist and a registered dietitian under the order of a licensed Physician; and
 2. the Medical Foods and Low Protein Food Modified Products are prescribed in accordance with Coverage Policy for the therapeutic treatment of a Medical Disorder Requiring Specialized Nutrients or Formulas.
- 3.27 **Prenatal Tests and Testing of Newborn Children.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for prenatal tests that meet Coverage Policy and testing of newborns during the newborn hospitalization/delivery for core medical conditions. A complete list of the prenatal and newborn core medical condition testing is available at the Arkansas Department of Health and the US Secretary of Health and Human Services.
- 3.28 **Testing and Evaluation.** Subject to all other terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, coverage is provided for the following testing and evaluation, limited to fifteen (15) hours per Covered Person per year. This benefit is further subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.
1. Psychological testing, including but not limited to, assessment of personality, emotionality and intellectual abilities.
 2. For Children under the age of six (6), childhood developmental testing, including but not limited to assessment of motor, language, social, adaptive or cognitive function by standardized developmental instruments.
 3. Neurobehavioral status examination, including, but not limited to assessment of thinking, reasoning and judgment.
 4. Neuropsychological testing, including, but not limited to Halstead-Reitan, Luria and WAIS-R.

5. Biomarker testing for the purpose of diagnosis, treatment, appropriate management or ongoing monitoring of cancer diagnoses. This benefit is not subject to the limitation of fifteen (15) hours per Covered Person per year.
- 3.29 **Complications of Smallpox Vaccine.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for complications resulting from a smallpox vaccination. This benefit is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.
- 3.30 **Neurologic Rehabilitation Facility Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for Neurologic Rehabilitation Facility services. This benefit is subject to the Deductible, Copayment and/or Coinsurance specified in the Schedule of Benefits. This Neurologic Rehabilitation Facility services benefit is subject to the following conditions:
1. The Covered Person must be suffering from Severe Traumatic Brain Injury;
 2. The admission must be within 7 days of release from an inpatient Hospital stay;
 3. The Neurologic Rehabilitation Facility services are of a temporary nature with a potential to increase ability to function;
 4. Custodial Care is not covered (See Subsections 4.3.7 and 9.26); and
 5. Coverage is provided for a maximum of 60 days per Covered Person per lifetime.
- 3.31 **Pediatric Vision Services.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, coverage is provided for the following pediatric vision services when performed or prescribed by a Physician subject to the Deductible, Copayment and Coinsurance amounts specified in the Schedule of Benefits.
1. Annual routine eye examinations with refraction are covered beginning at age six, or earlier if medically indicated, through age 18.
 2. One pair of lenses in a calendar year, if prescribed by a physician.
 - a. Lenses may be prescription glasses or contact lenses.
 - b. Lenses may be plastic or polycarbonate lenses.
 3. One frame in a calendar year if lenses are prescribed and prescription glasses selected.
 4. Eye Glass repair if glasses were originally covered by this Benefit Certificate.
 5. Replacement of lost or broken glasses, only one time within a year
 6. Eye prosthesis or polishing services
 7. Eyeglasses for children diagnosed as having the following diagnoses must have a surgical evaluation in conjunction with supplying eyeglasses:
 - a. Ptosis (droopy lid);
 - b. Congenital cataracts;
 - c. Exotropia or vertical tropia; or
 - d. Children between the ages of twelve (12) and twenty-one (21) exhibiting exotropia.
 8. Vision therapy developmental testing
 - a. orthoptic and pleoptic training with continuing medical direction and evaluation;
 - b. sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure);
 - c. developmental testing extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report.

- 3.32 **Adult Routine Eye Exams.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, coverage is provided for one routine vision examination every 2 years by a Provider who is an optometrist or ophthalmologist.
- 3.33 **Hearing Aid Benefits.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for a Hearing Aid sold by a professional licensed by the State of Arkansas to dispense a Hearing Aid or hearing instrument. Coverage shall be subject to member cost sharing but shall be limited to \$1,400 per Hearing Aid, per Covered Person with no limitation on the number of hearing aids received.
- 3.34 **Temporomandibular Joint Benefits.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate the applicable Coverage Policy, coverage is provided for the Allowance or Allowable Charges for medical treatment, including surgical and nonsurgical procedures, of temporomandibular joint disorder and craniomandibular disorder. This coverage shall be the same as that for treatment to any other joint in the body.
- 3.35 **Miscellaneous Health Interventions.** Subject to all other terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, coverage is provided for the following:
1. **Chelation Therapy.** Chelation therapy is generally not covered, see Subsection 4.214. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate and applicable Coverage Policy, chelation therapy for control of ventricular arrhythmias or heart block associated with digitalis toxicity, emergency treatment of hypercalcemia, extreme conditions of metal toxicity, including thalassemia intermedia with hemosiderosis, Wilson's disease (hepatolenticular degeneration), lead poisoning and hemochromatosis is covered
 2. **Clinical Trials.** Phase I, II, III or IV clinical trials or any study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis of a drug, device or medical treatment or procedure are not covered. See Subsection 4.3.3. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, Routine Patient Costs for items and services furnished in connection with participation in the clinical trial are covered, provided the Covered Person is eligible to participate and has been approved for participation in accordance with the protocols of the clinical trial and the clinical trial is an Approved Clinical Trial. See Subsection 9.8 .
 3. **Contraceptive Devices.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for contraceptive devices when prescribed by a Physician.
 4. **Crisis Stabilization Services.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for services provided to a Covered Person to address a serious behavioral health impairment during a period of detention, not to exceed ninety-six (96) hours, at a Crisis Stabilization Unit. This coverage is limited to one period of detention per month and a maximum of six periods of detention per Covered Person per calendar year.
 5. **Dietary and Nutritional Counseling Services.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, and subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits, coverage is provided for dietary and nutritional counseling services when provided in conjunction with Diabetic Self-Management Training, for services needed by Covered Persons in connection with cleft palate management and for nutritional assessment programs provided in and by a Hospital and approved by the Company.
 6. **Electrotherapy stimulators.** Treatment using electrotherapy stimulators are generally not covered, see Subsection 4.2.30. However, coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication.
 7. **Enteral Feedings.** Enteral feedings are generally not covered, see Subsection 4.2.32. However, enteral feedings are covered when such feedings have been approved and documented by an In-Network Physician as being the Covered Person's sole source of nutrition.

8. **Gastric Pacemaker Coverage.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate including the Deductible, Copayment and/or Coinsurance set out in the Schedule of Benefits; coverage is provided for gastric pacemakers
9. **Genetic Testing.** In general, genetic testing to determine: (1) the likelihood of developing a disease or condition, (2) the presence of a disease or condition in a relative, (3) the likelihood of passing an inheritable disease, condition or congenital abnormality to an offspring, (4) genetic testing of the products of amniocentesis to determine the presence of a disease, condition or congenital anomaly in the fetus, (5) genetic testing of a symptomatic Covered Person's blood or tissue to determine if the Covered Person has a specific disease or condition, and (6) genetic testing to determine the anticipated response to a particular pharmaceutical, are not covered.

However, subject to the terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, applicable Coverage Policy, a limited number of specific genetic tests may be covered for situations (3), (4) or (5) referenced above when the Company has determined that the particular genetic test (a) is the only way to diagnose the disease or condition, (b) has been scientifically proven to improve outcomes when used to direct treatment, and (c) will affect the individual's treatment plan. A limited number of specific genetic tests may be covered for situation (6) referenced above if criteria (b) and (c) above are met. The Company has full discretion in determining which particular genetic tests may be eligible for benefits as an exception to this exclusion. Any published Coverage Policy regarding a genetic test will control whether or not benefits are available for that genetic test as an exception to this exclusion.
10. **High Frequency Chest Wall Oscillators.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate including applicable Coverage Policy, coverage is provided, to Covered Person's with cystic fibrosis, for one high frequency chest wall oscillator during such Covered Person's lifetime. Coverage is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.
11. **Inotropic Agents for Congestive Heart Failure.** Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. See Subsection 4.2.52. However, subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, where the patient is on a cardiac transplant list at a Hospital where there is an ongoing cardiac transplantation program, the Plan will cover infusion of inotropic agents.
12. **Pilot Project Coverage.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, from time to time, the Company may provide coverage of medical interventions that are excluded under the terms of the Plan as set out in this Benefit Certificate, under terms, conditions, exclusions and limitations of a Company authorized Pilot Program. You can learn the medical interventions that are covered by a Company authorized Pilot Program, and the terms, conditions, exclusions and limitations of such coverage by visiting the Company's website at WWW.ARKANSASBLUECROSS.COM or by calling Customer Service.
13. **Trans-telephonic Home Spirometry.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, trans-telephonic home or ambulatory spirometry is covered for patients who have had a lung transplant.
14. **Vision Enhancement.** For persons 19 years and older vision enhancements are generally not covered, see Subsection 4.2.99. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non-infectious, and (2) the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. The Plan does not cover the implantation of a multifocal lens; however, if a multifocal lens is implanted after a cataract extraction, the Plan will pay the Allowance or Allowed Charge for a monofocal lens. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. See Subsection 3.12.4. In addition, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, certain

vision enhancement is provided to Covered Persons under the age of 19. See Subsection 3.30 - Pediatric Vision Services.

4.0 SPECIFIC PLAN EXCLUSIONS

Even if the Primary Coverage Criteria (See Section 2.0) are met, coverage of a particular service, supply or condition may not be covered under the terms of this Benefit Certificate. This Section 4.0 describes the conditions, Provider services, Health Interventions and miscellaneous fees or services for which coverage is excluded.

4.1 Health Care Providers.

1. Custodial Care Facility. Services or supplies furnished by an institution which is primarily a place of rest or a place for the aged are not covered. Youth homes, boarding schools, or any similar institution are not covered.
2. Freestanding Cardiac Care Facility. Treatment received at a Freestanding Cardiac Care Facility is not covered.
3. Immediate Relatives. Professional services performed by a person who ordinarily resides in the Covered Person's home, including self, or is related to the Covered Person as a Spouse, parent, Child, brother or sister, grandparent and grandchild, whether the relationship is by blood or exists in law are not covered.
4. Midwives, Not Certified. Services provided by a midwife who is not a licensed certified nurse midwife in the state where he or she renders services and who does not have a collaborative agreement with a Physician are not covered.
5. Physical Therapy Aide. Services or supplies provided by a physical therapy aide are not covered.
6. Provider, Excluded. Health Interventions received from any Provider who has been excluded from participation in any federally funded program, are not covered.
7. Provider, Undefined. Services or supplies provided by an individual or entity that is not a Provider as defined in this Benefit Certificate are not covered. (See Subsection 9.102 Provider.)
8. Recreational Therapist. Services or supplies provided by a recreational therapist are not covered.
9. Residents, interns, students or fellows. Services performed or provided by a Hospital resident, intern, student or fellow of any medical related discipline are not covered.
10. Surgical First Assistants. The Company does not recognize surgical first assistants as a covered provider eligible for reimbursement for Covered Services. Any services performed by a surgical first assistant will be denied.
11. Unlicensed Providers or Provider Outside Scope of Practice. Coverage is not provided for treatment, procedures or services received from any person or entity, including but not limited to Physicians, who is required to be licensed to perform the treatment, procedure or service, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not, in the opinion of the Company's Medical Director, include within its scope the treatment, procedure or service provided.

4.2 Health Interventions.

1. Abortion. Abortion is not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, pregnancy terminations under the direction of a Physician are covered, but only when performed in an In-Network Hospital or In-Network Outpatient Hospital setting.
2. Abuse of Medications. Medications, drugs or substances used in an abusive, destructive or injurious manner are not covered, except when caused by a mental or physical illness.
3. Acupuncture. Acupuncture and services related to acupuncture are not covered.

4. Adoptive Immunotherapy. Adoptive immunotherapy, including but not limited to (lymphokine-activated killer (LAK) therapy, tumor-infiltrating lymphocyte (TIL) therapy unless FDA approved for treatment of malignancy, autolymphocyte therapy (ATL)) is not covered. However, subject to Coverage Policy, chimeric antigen receptor T-cell therapy is covered in a Blue Distinction Center (BDC) approved facility.
5. Antigen immunotherapy. Antigen immunotherapy for repeat fetal loss is not covered.
6. Arthroereisis for Pes Planus (Flat Feet). This treatment is sometimes used to treat flat feet and is not covered.
7. Bereavement services. Medical social services and outpatient family counseling and/or therapy for bereavement, except if provided as Hospice Care, are not covered.
8. Biochemical Markers for Alzheimer's Disease. Measurement of cerebrospinal fluid and urinary biomarkers of Alzheimer's disease including but not limited to tau protein, amyloid beta peptides and neural thread proteins are not covered.
9. Biofeedback. Biofeedback and other forms of self-care or self-help training, and any related diagnostic testing are not covered for any diagnosis or medical condition.
10. Blood Typing. Blood Typing or DNA analysis for paternity testing is not covered.
11. Bone Growth Stimulation, electrical, as an adjunct to cervical or sacroiliac fusion surgery. Electrical Bone Growth Stimulation used as an adjunct to cervical fusion or sacroiliac surgery is not covered. However, Electrical Bone Growth, stimulation may be covered per respective medical coverage policies for some axial and appendicular skeleton conditions.
12. Bronchial Thermoplasty. Bronchial thermoplasty for treatment of asthma or other indications and bronchoscopy, when performed with bronchial thermoplasty, are not covered.
13. Chelation therapy. Services or supplies provided as, or in conjunction with, chelation therapy, are generally not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, chelation therapy for control of ventricular arrhythmias or heart block associated with digitalis toxicity, emergency treatment of hypercalcemia, extreme conditions of metal toxicity, including thalassemia intermedia with hemosiderosis, Wilson's disease (hepatolenticular degeneration), lead poisoning and hemochromatosis is covered. See Subsection 3.34.1.
14. Chemical Ecology. Diagnostic studies and treatment of multiple chemical sensitivities, environmental illness, environmental hypersensitivity disorder, total allergy syndrome or chemical ecology is not covered.
15. Cognitive Rehabilitation. Services or supplies provided as or in conjunction with, Cognitive Rehabilitation are not covered. See Subsection 9.15. However, subject to all terms, conditions, exclusions and limitation of the Plan as set forth in this Benefit Certificate, coverage is provided for Neurologic Rehabilitation Facility Services for Covered Persons with Severe Traumatic Brain Injury. See Subsection 3.29.
16. Cold Therapy. Cold Therapy devices are used in place of ice packs. The use of active or passive, intermittent or continuous, with or without pneumatic compression, cold therapy is not covered. Examples of cold therapy devices include, but are not limited to, the Cryocuff device, the Polar Care Cub device, the Autochill device, and the Game Ready device.
17. Compound Medications. Compound Medications are not covered.
18. Complications of non-covered treatments. Care, services or treatment required as a result of complications from a treatment or service not covered under this Benefit Certificate are not covered.
19. Compression Garments. All types of compression garments, support hose or elastic supports are not covered even when purchased with a Prescription. However, subject to all terms conditions, exclusions and limitation of the Plan as set forth in this Benefit Certificate, coverage is provided for

- compression garments specifically designed to treat severe burns or compression sleeves and gloves used to treat lymphedemas following mastectomy.
20. Cord Blood. The collection and/or storage of cord or placental blood cells for an unspecified future use as an autologous stem-cell transplant in the original donor or for some other unspecified future use as an allogeneic stem-cell in a related or unrelated donor is not covered.
 21. Coverage Policy. The Company has developed and published on its website specific Coverage Policies in relation to certain Health Interventions. If a Coverage Policy exists for an Intervention, the Coverage Policy shall determine whether such Intervention meets the Primary Coverage Criteria. If a Coverage Policy determines that a Health Intervention does not meet the Primary Coverage Criteria, this Plan does not provide coverage for that Intervention. The absence of a specific Coverage Policy with respect to any particular Health Intervention should not be construed to mean that the Intervention meets the Primary Coverage Criteria.
 22. Cranial electrotherapy or cranial electromagnetic stimulation devices. Cranial electrotherapy is not covered. Cranial electromagnetic or cranial magnetic stimulation devices are not covered unless a specific Coverage Policy provides coverage.
 23. Current Perception Threshold Testing. This testing performed as a substitute for standard nerve conduction studies in diagnosing carpal tunnel or tarsal tunnel syndrome is not covered.
 24. Dental Care. Dental Care, oral surgery, orthodontic services and Prosthodontic Services are generally not covered, except as provided in the Benefit Certificate. See Subsection 3.21. More specifically, Prosthodontic Services generally are not covered except as provided under 3.21.6.
 25. Dietary and Nutritional Services. Any services or supplies provided for dietary and nutritional services, other than conditions specified in Subsection 3.26, including but not limited to medical nutrition therapy, are not covered. Baby formula or thickening agents, whether prescribed by a Physician or acquired over the counter, is not a covered benefit. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for Medical Foods and Low Protein Modified Food Products for the treatment of a Medical Disorder Requiring Specialized Nutrients or Formulas. See Subsection 3.25.
 26. Digitization Computer Enhanced X-ray Analysis for Spinal Evaluation. Spinal visualization using digitization of spinal x-rays and computerized analysis of the back or spine is not covered.
 27. Dynamic Orthotic Cranioplasty. Dynamic orthotic cranioplasty is not covered.
 28. Dynamic spinal motion visualization techniques such as Digital Motion X-ray, Cineradiography and Videoradiography. The use of digital motion x-ray for the evaluation of musculoskeletal conditions is not covered.
 29. EKG, Signal Averaged. Signal averaged electrocardiography utilized to stratify risk for arrhythmias following myocardial infarction, in patients with cardiomyopathy, in patients with syncope, as an assessment of success after surgery for arrhythmia, in detection of acute rejection of heart transplants, as an assessment of efficiency of antiarrhythmic drug therapy and in the assessment of successful pharmacological, mechanical or surgical interventions to restore coronary blood flow is not covered.
 30. Electrotherapy and electromagnetic stimulators. All treatment using electrotherapy and electromagnetic stimulators, including services and supplies used in connection with such stimulators, and complications resulting from such treatment are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication. Coverage is also provided for neuromuscular electrical stimulation (NMES) for treatment of disuse atrophy where nerve supply to the muscle is intact, including but not limited to atrophy secondary to prolonged splinting or casting of the affected extremity, contracture due to scarring of soft tissue as in burn lesions and hip replacement surgery until orthotic training begins.

31. **Enhanced External Counterpulsation.** Enhanced external counterpulsation (EECP) is generally not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for one course of enhanced external counterpulsation for the treatment of disabling angina in patients who are NYHA Class III or IV, or equivalent classification; who have experienced inadequate control of anginal symptoms with a medication regimen that consists of optimal dosages of platelet inhibitors, beta-blockers, calcium channel blockers, long-acting nitrates, lipid-lowering drugs and antihypertensives when these drugs are appropriate and there is no contraindication to any of these drugs; and who are not amenable to surgical cardiac intervention such as angioplasty or coronary artery bypass grafting. Repeat courses of EECP are not covered.
32. **Enteral Feedings.** Enteral feedings are generally not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, enteral feedings are covered when such feedings have been approved and documented by an In-Network Physician as the Covered Person's sole source of nutrition.
33. **Environmental Intervention.** Services or supplies used in adjusting a Covered Person's home, place of employment or other environment so that it meets the Covered Person's physical or psychological condition are not covered.
34. **Epiduroscopy/spinal myelography.** This service is used in the diagnosis and treatment of spinal pain and is not covered.
35. **Excessive Use.** Excessive use of Medications is not covered. For purposes of this exclusion, each Covered Person agrees that the Company shall be entitled to deny coverage of medications on grounds of excessive use when the Company's medical director, in his sole discretion, determines (1.) that a Covered Person has exceeded the dosage level, frequency or duration of medications recommended as safe or reasonable by major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 42 U.S.C. §1395(x)(t)(2)(B), as amended, standard reference compendia or by the Pharmacy & Therapeutics Committee; or (2.) that a Covered Person has obtained or attempted to obtain the same medication from more than one Physician for the same or overlapping periods of time; or (3.) that the pattern of Prescription purchases, changes of Physicians or pharmacy or other information indicates that a Covered Person has obtained or sought to obtain excessive quantities of Medications. Each Covered Person hereby authorizes the Company to communicate with any Physician, health care Provider or pharmacy for the purpose of reviewing and discussing the Covered Person's Prescription history, use or activity to evaluate for excessive use.
36. **Exercise programs.** Exercise programs for treatment of any condition are not covered.
37. **Extracorporeal Shock Wave Therapy.** Extracorporeal shock wave therapy (ESWT) for any musculoskeletal condition, including but not limited to plantar fasciitis or tennis elbow, is not covered.
38. **Family Planning.** The following family planning services are not covered.
 - a. reversal of sterilization
 - b. surrogate mothers providing services for a Covered Person.
39. **Foot care.** Non-custom shoe inserts are not covered. Services or supplies for the treatment of subluxations of the foot, arthroeresis for flat feet, care of corns, bunions, (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet are not covered.
40. **Fraud or Material Misrepresentation.** Health Interventions, including but not limited to Medications, obtained by unauthorized or fraudulent use of the ID card or by material misrepresentation are not covered.
41. **Free Health Interventions.** Health Interventions, including but not limited to Medications, provided or dispensed without charge to the Covered Person or for which, normally (in professional practice), there is no charge, are not covered.

42. Genetic testing. In general, genetic testing to determine: (1) the likelihood of developing a disease or condition, (2) the presence of a disease or condition in a relative, (3) the likelihood of passing an inheritable disease, condition or congenital abnormality to an offspring, (4) genetic testing of the products of amniocentesis to determine the presence of a disease, condition or congenital anomaly in the fetus, (5) genetic testing of a symptomatic Covered Person's blood or tissue to determine if the Covered Person has a specific disease or condition, and (6) genetic testing to determine the anticipated response to a particular pharmaceutical, are not covered.

However, subject to the terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, applicable Coverage Policy, a limited number of specific genetic tests may be covered for situations (3), (4) or (5) referenced above when the Company has determined that the particular genetic test (a) is the only way to diagnose the disease or condition, (b) has been scientifically proven to improve outcomes when used to direct treatment, and (c) will affect the individual's treatment plan. A limited number of specific genetic tests may be covered for situation (6) referenced above if criteria (b) and (c) above are met. The Company has full discretion in determining which particular genetic tests may be eligible for benefits as an exception to this exclusion. Any published Coverage Policy regarding a genetic test will control whether or not benefits are available for that genetic test as an exception to this exclusion.

43. Hair loss or growth. Wigs, hair transplants or any Medication (e.g., Rogaine, Minoxidil, etc.) that is taken for hair growth, whether or not prescribed by a Physician, are not covered regardless of the cause of hair loss. Treatment of male or female pattern baldness is not covered.

44. Hearing devices or talking aids. Regardless of the reason for the hearing or speech disability, Prosthetic Devices to assist hearing (except for hearing aids as covered in Subsection 3.32) or talking devices including special computers are not covered. The testing for, the fitting of or the repair of such Prosthetic Devices to assist hearing or talking devices is not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, coverage is provided for:

- a. cochlear implant (an implantable hearing device inserted into the modiolus of the cochlea and into cranial bone) and its associated speech processor up to a lifetime maximum benefit of one cochlear implant per year per Covered Person unless replacement is necessitated because there is inadequate response to existing component(s) that interfere with the Covered Person's activities of daily living or one or more components are no longer functional and cannot be repaired; and
- b. one auditory brain stem implant per lifetime for an individual twelve years of age and older with a diagnosis of Neurofibromatosis Type II (NF2) who has undergone or is undergoing removal of bilateral acoustic tumors.
- c. surgically implantable osseointegrated hearing aid for patients with single-sided deafness and normal hearing in the other ear. limited to Covered Persons with
 - i. congenital or surgically induced malformations (e.g., atresia) of the external ear canal or middle ear;
 - ii. chronic external otitis or otitis media;
 - iii. tumors of the external canal and/or tympanic cavity; and
 - iv. sudden, permanent, unilateral hearing loss due to trauma, idiopathic sudden hearing loss, or auditory nerve tumor.

45. Heat Bandage. Treatment of a wound with a Warm-up Active Wound Therapy device or a noncontact radiant heat bandage is not covered.

46. High dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Non-Myeloablative Allogeneic Stem Cell Transplantation. High dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Non-Myeloablative Allogeneic Stem Cell Transplantation are not covered except in accordance with the Company's specific Coverage Policies. See Subsection 3.24.

47. Hippo Therapy. Hippo therapy is not covered.
48. Home delivery. Services and supplies received in connection with childbirth in the home are not covered regardless of the Provider.
49. Home Uterine Activity Monitor. Home uterine activity monitors or their use is not covered.
50. Hypnotherapy. Hypnotherapy is not covered for any diagnosis or medical condition.
51. Illegal Uses. Medications, drugs or substances that are illegal to dispense, possess, consume or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner, are not covered.
52. Inotropic Agents for Congestive Heart Failure. Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, where the patient is on a cardiac transplant list at a Hospital where there is an ongoing cardiac transplantation program, the Plan will cover infusion of inotropic agents.
53. Interspinous Distraction Devices (Spacers). These devices are inserted between the spinous processes, and they act as a spacer between the spinous processes. Their proposed use is to treat leg and/or back pain secondary to spinal stenosis and distract the spinous processes and restrict extension. Interspinous Distraction Devices (Spacers) are not covered. Examples include, but are not limited to, the X-STOP interspinous Process by Medtronic, the Wallis System by Abbott Spine, the Coflex implant by Paradigm Spine, the ExtendSure and CoRoent devices by NuVasive, the NL-Prow by NonLinear Technologies, the Aperius by Medtronic Spine.
54. Intraoperative Neurophysiologic Monitoring (IONM). IONM is used to monitor the integrity of neural pathways during high-risk neurosurgical cranial/spinal, orthopedic spinal, vascular, and major thyroid procedures and is not covered unless the physician performing this service is a licensed physician other than the operating surgeon. Coverage for IONM is provided only when the condition(s) and criteria specified in Coverage Policy are met.
55. Laser Treatment of Spinal Intradiscal and Paravertebral Disc Disorders. Laser treatment of spinal intradiscal and paravertebral disc disorders is not covered.
56. Learning Disabilities. Services or supplies provided for learning disabilities, i.e., reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty and other learning difficulties, are not covered.
57. Lost Medications. Replacement of previously filled Prescription Medications because the initial Prescription Medication was lost, stolen, spilled, contaminated, etc. are not covered.
58. Measurement of Exhaled Nitric Oxide. Measurement of Exhaled Nitric Oxide used in the diagnosis and management of asthma and other respiratory disorders is not covered.
59. Measurement of Lipoprotein-Associated Phospholipase (Lp-PLA2). Measurement of Lipoprotein-Associated Phospholipase (Lp-PLA2), also known as platelet-activating factor acetylhydrolase is not covered. The proposed use of this test is to assess cardiovascular risk.
60. Measurement of Novel Lipid Risk Factors in Risk Assessment and Management of Cardiovascular Disease. Measurement of novel lipid risk factors including, but not limited to, apolipoprotein B, apolipoprotein A-1, HDL subclass, LDL subclass, apolipoprotein E, and Lipoprotein A are not covered.
61. Measurement of Serum intermediate Density Lipoproteins (remnant-like particles). These lipoproteins have a density that falls between low density lipoproteins and very low-density lipoproteins. Measurements of these "remnant-like" particles are not covered.
62. Medical Supplies. Medical Supplies that can be purchased without a prescription or over the counter, whether or not a prescription was obtained, are not covered; for example, medication coated dressings, tape and gauze are not covered even with a Physician Prescription. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate,

Medical Supplies necessary for the management of diabetes mellitus or for home health services are covered. See Subsection 3.13 Medical Supplies, Subsection 3.15 Diabetes Management Services and Section 3.19 Home Health Services. Expenses for Medical Supplies provided in a Physician's office are included in the reimbursement for the procedure or service for which the supplies are used.

63. Medication Therapy Management Services. Medication therapy management services by a pharmacist, including but not limited to a review of a Covered Person's history and medical profile, an evaluation of Prescription Medication, over-the-counter medications and herbal medications, are not covered.
64. Mobile Cardiac Outpatient Telemetry (MCOT). Mobile Cardiac Outpatient Telemetry is sometimes used in patients who experience infrequent symptoms suggestive of cardiac arrhythmias. MCOT is not covered.
65. Naturopath/Homeopath Treatment. Naturopathic or Homeopathic treatments of any condition are not covered.
66. Neural Therapy. Neural therapy often involves the injection of a local anesthetic into scars, trigger points, acupuncture points, tendon insertions, ligament insertions, peripheral nerves, autonomic ganglia, the epidural space and other tissues to treat chronic pain and illness. Neural therapy is not covered.
67. Neurofeedback. The proposed use of Neurofeedback has been to reinforce neurobehavior modification in patients with certain neurological and/or neurobehavioral disorders such as ADD, ADHD, Parkinson's Disease, epilepsy, insomnia, depression, mood disorders, post-traumatic stress disorder, alcoholism, drug addiction, menopausal symptoms and migraine headaches. Neurofeedback is not covered.
68. Off-Label Use. (a) Except as provided in subsection (b) (c) or (d) of this subsection, Prescription Medications and devices that are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which FDA approval is given are not covered. (b) From time to time a particular clinical use of a Prescription Medication may be determined to be safe and efficacious by the Company's medical director, managed pharmacy director, or the Pharmacy and Therapeutics Committee, even without labeling of such indication or use by the FDA. This occurs because of clear and convincing evidence from the Medical Literature, and often in consultation with practicing Physicians of the appropriate specialty in the community. Such "off-label" use will be covered, though Prior Approval is often (but not always) required. Other than the list of Medications requiring Prior Approval cited above, a complete list of Medications and their approved off-label indications is not available. (c) "Off-label" use of intravenous immunoglobulin, also known as "IVIG", to treat Covered Persons diagnosed with pediatric acute-onset neuropsychiatric syndrome and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection, or both, is covered subject to the terms, conditions, exclusions and limitations set out in Coverage Policy. (d) A Prescription Medication approved by the FDA for the treatment of cancer, though not approved to treat the specific cancer for which it has been prescribed, will be covered provided:
 - i. the Prescription Medication has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as "not indicated" or otherwise inappropriate or not recommended, in one or more of these standard reference compendia: (A) The American Hospital Formulary Service Drug Information; (B) The National Comprehensive Cancer Network Drugs and Biologics Compendium with a level 1 or 2A recommendation; (C) The Elsevier Gold Standard's Clinical Pharmacology; or
 - ii. the Prescription Medication has been recognized as safe and effective for treatment of that specific type of cancer in two (2) articles from Medical Literature that have not had their recognition of the Prescription Medication's safety and effectiveness contradicted by clear and convincing evidence presented in another article from Medical Literature; or

- iii. other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services or the commissioner may be used to provide coverage by the Company at the Company's discretion.
- 69. Oral, Implantable and Injectable Contraceptives. Oral, implantable and injectable contraceptive drugs, and Prescription barrier methods that are not on the Formulary are not covered.
- 70. Orthoptic, Pleoptic or Vision Therapy. Orthoptic, pleoptic or vision therapy services are generally not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set out in this Benefit Certificate, coverage is provided for office-based orthoptic training in the treatment of convergence insufficiency when supported by the Coverage Policy on Orthoptic Training for the Treatment of Vision and Learning Disabilities. Pleoptic training is covered for children under 19.
- 71. Out-of-Network Infertility. Testing, counseling and planning services for infertility are not covered when provided by Out-of-Network Providers.
- 72. Out-of-Network Preventive Health Services. Preventive health services are not covered when provided by Out-of-Network Provider.
- 73. Out-of-Network Reconstructive Surgery. Services rendered for any Reconstructive Surgery, including reduction mammoplasty, are not covered when rendered by an Out-of-Network Provider.
- 74. Out-of-Network Therapy. Services rendered Out-of-Network for physical, occupational and speech therapy, chiropractic services and cardiac rehabilitation therapy are not covered.
- 75. Over the Counter Medications. Over-the-counter Medications (except insulin) are not covered without a Prescription from a Physician.
- 76. Pain Pump, Disposable. Disposable pain pumps following surgery are not covered.
- 77. Percutaneous discectomy and Radio-frequency Thermocoagulation. Any method of percutaneous discectomy, including, but not limited to, automated or manual percutaneous discectomy, laser discectomy, radiofrequency nucleotomy or nucleolysis, and coblation therapy, is not covered. Radio-frequency Thermocoagulation or Intradiscal electrothermal therapy for discogenic or other forms of back pain are not covered.
- 78. Percutaneous Sacroplasty. Percutaneous sacroplasty is not covered.
- 79. Peripheral Vascular Disease Rehabilitation Therapy. Peripheral vascular disease rehabilitation therapy is not covered.
- 80. Prolotherapy. Prolotherapy or Sclerotherapy for the stimulation of tendon or ligament tissue or for pain relief in a localized area of musculoskeletal origin is not covered.
- 81. Radio-frequency Thermal Therapy for Treatment of Orthopedic Conditions. The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered.
- 82. Rest cures. Services or supplies for rest cures are not covered.
- 83. Seasonal Affective Disorder (SAD). Use of photo therapy or light therapy to treat seasonal affective disorder or depression is not covered.
- 84. Sensory Stimulation for Coma Patients. Sensory stimulation, whether visual, auditory, olfactory, gustatory, cutaneous or kinesthetic, for coma patients is not covered.
- 85. Sexual Enhancement Medications. Medications used for the treatment of sexual enhancement, including but not limited to medications for erectile dysfunction, are not covered regardless of the reason(s) for the sexual dysfunction.
- 86. Short stature syndrome. Any services related to the treatment of short stature syndrome, except for laboratory documented growth hormone deficiency, are not covered.
- 87. Sleep Apnea, Portable Studies. Studies for the diagnosis, assessment or management of obstructive sleep apnea are generally not covered. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for portable (at

- home) sleep studies when all of the following seven channel monitoring information is included: EEG, heart rate, Chin EMG, ECG, airflow, effort and oxygen saturations, channels to identify awake versus asleep and apnea events. Devices used are considered portable comprehensive polysomnography devices monitoring a minimum of seven channels.
88. Smoking cessation/Caffeine addiction. Treatment of caffeine or nicotine addiction, smoking cessation Prescription Medication products not on our Formulary, including, but not limited to, nicotine gum and nicotine patches without a written Prescription, are not covered
 89. Snoring. Devices, procedures or supplies to treat snoring are not covered.
 90. Spinal Manipulation under general anesthesia. This type of manipulation is sometimes used for treatment of arthrofibrosis of the knee or shoulder and is intended to overcome the patient's protective reflex mechanism. Spinal manipulation under anesthesia is not covered.
 91. Spinal Uploading Devices for treatment of low back pain. Spinal uploading devices including, but not limited to, gravity dependent and pneumatic devices are not covered. Examples include, but are not limited to, the Orthotrac Pneumatic Vest and other thoracic-lumbar-sacral orthotics which provide trunk support.
 92. Substance Addiction. Medications used to sustain or support an addiction or substance dependency are not covered. However, the use of designated agonist (e.g., methadone or buprenorphine) as part of a comprehensive substance abuse treatment plan is covered.
 93. Tanning equipment or salon. The purchase or rental of tanning equipment, supplies or the services of a tanning salon are not covered.
 94. Thermography. Thermography, the measuring of self-emanating infrared radiation that reveals temperature variation at the surface of the body, is not covered.
 95. Thoracoscopic Laser Ablation of Emphysematous Pulmonary Bullae. Thoracoscopic laser ablation of emphysematous pulmonary bullae is not covered.
 96. Total Facet Arthroscopy. Facet arthroscopy refers to the implantation of a spinal prosthesis to restore posterior element structure and function as an adjunct to neural decompression surgery. Total Facet Arthroscopy is not covered. Examples of facet arthroplasty devices include, but are not limited to, the ACADIA facet replacement System, the Total Facet Arthroscopy System and the Total Posterior-element System (TOPS).
 97. Transplant procedures. The following transplant procedures and services are not covered:
 - a. Solid organ transplants of any kind are not covered for a Covered Person with a malignancy of any kind that is presently active, in partial remission or in complete remission less than two years (e.g., non-metastatic resectable squamous and basal cell carcinoma of the skin are excepted.). A solid organ transplant of any kind is not covered for a Covered Person that has had a malignancy removed or treated in the 3 years prior to the proposed transplant. For purposes of this section, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma or melanoma, and breast. Exceptions to this non-coverage are (i) hepatocellular carcinoma under certain circumstances, as outlined in the Coverage Policy for hepatocellular carcinoma, and (ii) basal cell and squamous cell carcinomas of the skin, absent lymphatic or distant metastasis.
 - b. Organ transplants not authorized by Coverage Policy are not covered.
 98. Ultrasounds. More than one basic level obstetrical ultrasound during Routine Prenatal Care is not covered.
 99. Viscosupplementation for treatment of Osteoarthritis. Intra-articular hyaluronan such as Synvisc, Hyalgan, Supartz, Orthovisc and Euflexxa are not covered.

100. Vision enhancement. For Covered Persons age 19 or older, any procedure, treatment, service, equipment or supply used to enhance vision by changing the refractive error of the eye is not covered. Examples of non-covered visual enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses, intraocular lenses, and Refractive Keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e., corneal transplantation, cataract extraction, etc. Laser Assisted In Situ Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non-infectious, and (2) the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. Eyeglass frames are subject to a \$65 maximum Allowance or Allowable Charge. See Subsection 3.12.4. In addition, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, certain vision enhancement is provided to Covered Persons under the age of 19. See Subsection 3.30 - Pediatric Vision Services.
101. Vitamins or Baby Formula. Vitamins or food/nutrient supplements, except those that are Prescription Medications not available over the counter, are not covered. Baby formula and thickening agents, even if prescribed by a Physician, is not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for Medical Foods and Low Protein Modified Food Products for the treatment of Medical Disorder Requiring Specialized Nutrients or Formulas. See Subsection 3.25.
102. Vocational rehabilitation. Vocational rehabilitation services, vocational counseling and testing, employment counseling or services to assist a Covered Person in gaining employment, are not covered.
103. Weight Control. Medications prescribed, dispensed or used for the treatment of obesity, or for use in any program of, weight control, weight reduction, weight loss or dietary control are not covered. Weight loss surgical procedures, including complications relating thereto, are not covered.
104. Whole body computed tomography. Whole body computed tomography is not covered.
105. Wilderness Therapy. Wilderness therapy is not covered.
106. Wound Treatment. Blood derived growth factors are not covered.
107. Wound Vacuum Assisted Closure (VACs). Wound VAC are not covered without meeting Coverage Policy.

4.3 **Miscellaneous Fees and Services.**

1. Administrative Fees. Fees incurred for acquiring or copying medical records, sales tax, preparation of records for insurance carriers or insurance agencies, medical evaluation for life, disability or any type of insurance coverage are not covered.
2. Appointments. Charges resulting from the failure to keep a scheduled visit with a Physician or other Provider are not covered.
3. Clinical Trials. Phase I, II, III or IV clinical trials or any study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis of a drug, device or medical treatment or procedure are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, routine patient costs for items and services furnished in connection with participation in the trial are covered. See Subsection 3.34.2.
4. Comfort items. Personal hygiene or comfort items including but not limited to, spray nozzle, heating pad, heating lamp, hot water bottle, ice cap, television, radio, telephone, guest meals, whirlpool bath,

adjustable bed, automobile/van conversion or addition of patient lifts, hand control, or wheelchair ramp, and home modifications such as overhead patient lift and wheelchair ramps are not covered.

5. Cosmetic Services. All services or procedures related to or complications resulting from Cosmetic Services are not covered even if coverage was provided through a previous carrier.
6. Court ordered or third party recommended treatment. Services required or recommended by third parties, including physicals and/or vaccines/immunizations for employment, overseas travel, camp, marriage licensing, insurance, and services ordered by a court or arranged by law enforcement officials, unless otherwise covered by the Plan, are not covered.
7. Custodial Care. Services or supplies for custodial, convalescent, domiciliary or supportive care and non-medical services to assist a Covered Person with activities of daily living are not covered. (See Subsection 9.26 - Custodial Care.)
8. Donor services. Services or supplies incident to organ and tissue transplant, or other procedures when the Covered Person acts as the donor are not covered except for Autologous services.

When the Covered Person is the potential transplant recipient, a living donor's Hospital costs for the removal of the organ are covered with the following limitations:

- a. Allowance or Allowable Charges for the organ removal as well as any complications resulting from the organ removal are only covered for the period beginning on the day before the transplant to the date of discharge or 39 days, whichever is less.
 - b. Services for testing of a donor who is found to be incompatible are not covered.
9. Education Programs. Education programs, including but not limited to physical education programs in a group setting, health club memberships, athletic training, back schools, Work Hardening and Work Integration (Community) training, are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for Diabetes Self-Management Training. See Subsection 3.15.
 10. Excess charges. The part of an expense for care and treatment of an illness or Accidental Injury that is in excess of the Allowance or Allowable Charge is not covered.
 11. Postage or Delivery Charges. Charges for shipping, packaging, handling or delivering Medications are not separately covered.
 12. Prescription Medications used in connection with Health Interventions Not Covered by Plan. Prescription Medications used or intended to be used in connection with or arising from a treatment, service, condition, sickness, disease, injury, or bodily malfunction that is not covered under this Benefit Certificate, or for which this Benefit Certificate's benefits have been exhausted, are not covered.
 13. Services Received Outside the United States. Services or supplies received outside of the United States of America shall not be covered except at the sole discretion of the Company.
 14. Telephone and Other Electronic Consultation. Subject to all other terms, conditions, exclusions, and limitations of this Plan set forth in this Benefit Certificate.
 - i. Coverage is provided for Telemedicine services performed by a Provider licensed, certified, or otherwise authorized by the laws of Arkansas to administer health care in the ordinary course of the practice of his or her profession at the same rate as if it had been performed in-person provided the Telemedicine service is comparable to the same service provided in person.
 - ii. However, electronic consultations such as, but not limited to, telephonic, interactive audio, fax, text messaging, email, or for services, which are, by their nature, hands-on (e.g., surgery, interventional radiology, coronary, angiography, anesthesia, and endoscopy) are not covered. Audio-only communication is covered if it is real-time, interactive and substantially meets the requirements for a Covered Service that would otherwise be covered by the Plan.

- iii. Communications made by a Physician responsible for the direct care of a Covered Person in Case Management with involved health care Providers, or consultative electronic communication between a Primary Care Physician and other health care Providers regarding a Covered Person's care, however, are covered.
- 15. Travel or accommodations. Travel or transportation as a treatment or to receive consultation or treatment, except Ambulance Services covered under Subsection 3.17, are not covered. Accommodations, while receiving treatment or consultation or for any other purpose, are not covered.
- 16. War. Services or supplies provided for treatment of disease or injuries sustained while serving in the military forces of any nation are not covered.
- 17. Workers Compensation. Treatment of any compensable injury, as defined by the Workers' Compensation Law is not covered, regardless of whether or not the Covered Person filed a claim for workers' compensation benefits in a timely manner. See Subsection 5.3 Other Plans and Benefit Programs.

5.0 PROVIDER NETWORK AND COST SHARING PROCEDURES

The plan may afford you significant savings if you obtain coverage from Providers who are Providers in our Preferred Provider Organization ("Preferred Providers") or other health care Providers who have contracted with the Company ("Contracting Providers"). This Section explains how you can maximize your benefits under the Plan by using Preferred Providers and Contracting Providers, see Subsection 5.1. Under your plan, you are responsible for part of the costs associated with Covered Services, supplies, equipment and treatment. Your responsibilities are explained in this Section, see Subsection 5.2. Finally, this Section explains how costs of benefits that are covered by another benefit plan are covered by the Plan, see Subsection 5.3.

5.1 Network Procedures

- 1. **Standard Benefits.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, coverage is provided for Health Interventions you receive from a Provider as defined by the Plan. See Subsection 9.102.
- 2. **Preferred Provider Organization (PPO).** This coverage is most effective and advantageous for you when the services of Preferred Providers are used. Claims associated with services provided by Preferred Providers may have a more advantageous Deductible, Coinsurance and Copayment than claims for services of Non-Preferred Providers. For the definitions and explanation of the terms "Deductible," "Coinsurance," and "Copayment" please refer to Section 9.0 Glossary of Terms and Subsection 5.2.

The PPO or In-Network Deductible, Coinsurance and Copayment set forth in the Schedule of Benefits are applied to Allowable Charges for services and supplies you receive from a Preferred Provider, unless the Schedule of Benefits or this Benefit Certificate shows a different Deductible, Coinsurance or Copayment for the particular service.

- 3. **Non-PPO Benefits.** Reimbursement for services by Non- Preferred Providers generally will be less than payment for the same services when provided by a Preferred Provider and could result in substantial additional out-of-pocket expense. The Non-PPO or Out-of-Network Deductible, Coinsurance and Copayment set forth in the Schedule of Benefits are applied to Allowable Charges for services and supplies you receive from a Non-Preferred Provider unless:
 - a. **Plan Provision.** The Schedule of Benefits or this Benefit Certificate provides a different Deductible, Coinsurance or Copayment for the particular service or supply that is the subject of the claim;
 - b. **Emergency Services.** The intervention is for Emergency Care (see Subsection 9.38) and initial services are provided within forty-eight (48) hours of the onset of the injury or illness, in which case the In-Network Deductible, Coinsurance and Copayment apply;
 - c. **Continuity of Care, Prior to Coverage.** You notify the Company that prior to the effective date of your coverage, you were engaged with a Non-Preferred Provider for a scheduled

procedure or ongoing treatment covered under the terms of this Plan, that such procedure or treatment is for a condition requiring immediate care, and that you request PPO benefits for such scheduled procedure or ongoing treatment. If the Company approves PPO coverage for the scheduled procedure or ongoing treatment, In-Network Deductible, Coinsurance and Copayment will apply to claims for services and supplies rendered by the Non-Preferred Provider for such condition after the Company's approval until the procedure or treatment ends or until the end of ninety (90) days, whichever occurs first;

- d. **Continuity of Care, Pregnancy, Prior to Coverage.** You notify the Company that prior to the effective date of your coverage, you were receiving obstetrical care from a Non-Preferred Provider for a pregnancy covered under the terms of this Benefit Certificate, that you were in the third trimester of your pregnancy on the effective date of your coverage, and that you request PPO benefits for continuation of such obstetrical care from this Non-Preferred Provider. If the Company approves PPO coverage for the requested obstetrical care, In-Network Deductible, Coinsurance and Copayment will apply to claims for services and supplies received from this Non-Preferred Provider after the Company's approval and will continue to apply to claims for services and supplies rendered by the Non-Preferred Provider until the completion of the pregnancy, including two (2) months of postnatal visits;
- e. **Provider Leaves PPO.** You notify the Company that your Non-Preferred Provider was formerly a Preferred Provider when your ongoing treatment for an acute condition began and that you request PPO benefits for the continuation of such ongoing treatment. If the Company approves PPO coverage for the ongoing treatment, In-Network Deductible, Coinsurance and Copayment will apply to claims for services and supplies rendered by the Non-Preferred Provider for such condition after the Company's approval until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first;
- f. **Provider Leaves PPO, Pregnancy.** You notify the Company that your Non-Preferred Provider was formerly a Preferred Provider when you began receiving obstetrical care for a pregnancy covered under the terms of the Plan, that you were in the third trimester of your pregnancy on the date that the Provider left the PPO, and that you request PPO benefits for continuation of such obstetrical care from this Non-Preferred Provider. If the Company approves PPO coverage for the requested Obstetrical Care, In-Network Deductible, Coinsurance and Copayment will apply to services and supplies received from this Non-Preferred Provider after the Company's approval and will continue to apply to claims for services and supplies rendered by the Non-Preferred Provider until the completion of the pregnancy, including two (2) months of postnatal visits.
- g. **Continuity of Care, Coverage Ends.** You notify the Company that prior to the termination date of the Group Plan, you were engaged with a Preferred Provider for a scheduled procedure or ongoing treatment covered under the terms of this Plan, that such procedure or treatment is for a condition requiring transitional care, that the provider or treatment is not available under the new Group Plan, and that you request PPO benefits for such scheduled procedure or ongoing treatment. If the Company approves PPO coverage for the scheduled procedure or ongoing treatment, In-Network Deductible, Coinsurance and Copayment will apply to claims for services and supplies rendered by the Preferred Provider for such condition after the Company's approval until the procedure or treatment ends or until the end of ninety (90) days, whichever occurs first;
- h. **Company Approval.** You notify the Company prior to receiving a Health Intervention and the Company has determined that the required Covered Services or supplies associated with such Health Intervention are not available from a Preferred Provider and has provided you a written approval of in-network coverage for such services or supplies, In-Network Deductible, Coinsurance and Copayment will apply to the claims for the services that you receive from the Non-Preferred Provider.

Notification to the Company of requests either for payment of out-of-network services or supplies at in-network benefit level or for transitional care due to a Group Policy termination, should be made by writing Arkansas Blue Cross and Blue Shield, Attention: Medical Audit

and Review Services, Post Office Box 3688, Little Rock, Arkansas 72203, and should be received at least 15 working days prior to your receipt of such services or supplies. See Section 7.0 for procedures related to urgent care requests.

4. **No Balance Billing from Preferred Providers and Contracting Providers.** Preferred Providers and Contracting Providers are Physicians or Hospitals who are paid directly by the Company and have agreed to accept the Company's payment for Covered Services as payment in full except for your Deductible, Coinsurance, Copayment and any specific benefit limitation, e.g., Home Health visits are limited to (fifty) 50 per year (Subsection 3.19), if applicable. **A Covered Person is responsible for billed charges in excess of the Company's payment when Physicians or Hospitals who are neither a Preferred Provider nor a Contracting Provider render services except in specific instances listed in 5.1.7.b. These excess charges could amount to thousands of dollars in additional out of pocket expenses to the Covered Person.**
5. **Preferred Provider Directory.** The determination of whether a Physician or Hospital is a Preferred Provider, Non-Preferred Provider, Contracting Provider or Non-Contracting Provider is the responsibility of the Company. The Company can provide a list of Preferred Providers and Contracting Providers. You may also obtain a list of Preferred Providers and Contracting Providers on the Company's web site WWW.ARKANSASBLUECROSS.COM. A Provider's status may change. You can verify the Provider's status by calling Customer Service. **If you are informed incorrectly by Us prior to receiving a Covered Service, either by accessing our directory or in our response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing that would be no greater than if the Covered Service had been provided by an In-Network Provider**

BlueCard PPO Program. Your plan includes the BlueCard PPO benefit. This benefit allows you to receive PPO in-network benefits from a Provider, as defined in Subsection 9.102, located outside of Arkansas, provided such Provider is in the PPO network of the local Blue Cross or Blue Shield Company. You may obtain a list of the PPO Providers in an out-of-Arkansas location or verify the status of an out of state Provider by calling (800) 810-2583.

6. **Provider Status may Change.** It is possible that you might not be able to obtain services from a particular Preferred Provider. The network of Providers is subject to change. You might find that a particular PPO Provider may not be accepting new patients. If a Provider leaves the Network or is otherwise not available to you, you must choose another PPO Provider to get In-Network benefits.
7. **Out-of- Network Providers**
 - a. **NOTICE: Certain Services may not be In-Network Benefits.** Additional costs, including balance billing, may be incurred for a covered Health Intervention, e.g., anesthesia, radiology, or laboratory tests, provided by a non-PPO Provider in a PPO Hospital unless it meets the exception as provided in Subsection 5.1.7.b. These additional charges may not count toward the In-network Annual Limitation on Cost Sharing. **Do not assume that a PPO Provider's agreement includes all covered benefits or that all services provided at a PPO Hospital are provided by PPO Provider** Some PPO Providers contract with the Company to provide only certain covered benefits, but not all covered benefits. Some Providers choose to be a PPO Provider for only some of our products. Refer to the Provider directory, ask your Provider or contact Customer Service for assistance. **Your Provider may not be In-Network for all services.**
 - b. Balance billing by Out-of-Network Providers is prohibited in the following instances:
 - i. When Ancillary Services, as described in the No Surprises Act, are received at certain In-Network facilities on a non-emergency basis from Out-of-Network Providers.
 - ii. When non-Ancillary Services are received at certain In-Network facilities on a non-emergency basis from Out-of-Network Providers who have not satisfied the notice and consent criteria as described in the Act.
 - iii. When Emergency Care services are provided by an Out-of-Network Provider.

- iv. When air Ambulance Services, as described in Subsection 3.17, are provided by an Out-of-Network Provider.

In these instances, the Out-of-Network Provider may not bill you for amounts in excess of your applicable Copayment, Coinsurance or Deductible (cost share). Except for air ambulance, your cost share is based on the Recognized Amount as described in the No Surprises Act and as set forth in the Glossary of Terms. Your cost share for air ambulance is based on the rates that would apply if the service was provided by an In-Network Provider.

When Covered Services are received from Out-of-Network Providers as stated above, Allowed Amounts are based upon one of the following as applicable:

- The initial payment made by Us or the amount subsequently agreed to by the Out-of-Network Provider and Us.
- The amount determined by *Independent Dispute Resolution (IDR)*.

8. **Relation of the Company to Providers.** The decision about whether to use a Preferred Provider or a Contracting Provider is the sole responsibility of a Covered Person. Neither Preferred Providers nor Contracting Providers are Policyholders or agents of the Company. The Company makes no representations or guarantees regarding the qualification or experience of any Provider with respect to any service. The evaluation of such factors and the decision about whether to use any Provider is the sole responsibility of the Covered Person.

9. **Scope of Provider Payment - Global Payment.** The Company's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowance or Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Benefit Certificate with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Benefit Certificate, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Benefit Certificate are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company and permitted or facilitated such

company's access to the physician's patient. In any event, as noted above, no benefits are available under this Benefit Certificate for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Benefit Certificate is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Benefit Certificate shall nevertheless be limited to one Allowance or Allowable Charge per CPT or HCPCS code; in such circumstances, your benefits under this Benefit Certificate will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowance or Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Preferred Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Benefit Certificate are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Benefit Certificate will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

5.2. Covered Person's Financial Obligations for Allowance or Allowable Charges under the Plan

1. **Deductible.** For those covered Health Interventions, which are specified in the Schedule of Benefits as being subject to a Deductible, each calendar year, before the Plan makes a Coinsurance benefit payment, a Covered Person must pay the cost of a Covered Service equal to the Annual Deductible Limitation specified in the Schedule of Benefits. If the Plan provides family coverage, once two family members have met their individual Deductible, no further Deductible will be required for the balance of the year, regardless of what member of the family incurs a claim. Deductible payments count toward the Annual Limitation on Cost Sharing specified in the Schedule of Benefits.

Expenses incurred and applied toward the Deductible during the last three (3) months of a calendar year may also be used to satisfy the Deductible for the succeeding calendar year.

2. **Coinsurance.** Once the Deductible is satisfied, a Covered Person is responsible for Coinsurance, which is a percentage of the Allowance or Allowable Charges paid, for claims incurred until the payment equals the Annual Limitation on Cost Sharing specified in the Schedule of Benefits. After the Annual Limitation on Cost Sharing is satisfied, subject to the provisions of Subsection 5.2.4 of this Benefit Certificate, the Covered Person will have no further responsibility with respect to Allowances or Allowable Charges incurred during the balance of the calendar year.
3. **Copayments.** In order to receive certain Health Interventions from an In-Network Provider, a Covered Person may have to pay a Copayment, which is expressed as either a dollar amount or a percentage of the Allowance or Allowable Charge in the Schedule of Benefits. Copayments count toward the Annual Limitation on Cost Sharing specified in the Schedule of Benefits.
4. **Allowable Charges Not Applicable to Annual Limitation on Cost Sharing.** No Allowance or Allowable Charges paid for services or supplies from Non-Preferred Providers shall accumulate to or be impacted by the satisfaction of the Annual Deductible Limitation or the Annual Limitation on Cost Sharing, unless the Company determines that the Non-Preferred Provider should be treated as a Preferred Provider in accordance with one of the provisions listed in Subsection 5.1.3.

5.3 Other Plans and Benefit Programs

1. **Coordination of Benefits.** Coordination of Benefits (COB) applies when a Covered Person has coverage under more than one Health Benefit Plan. The Company may annually request that a Covered Person verify the existence of other coverage.
 - a. **Definitions.** For purposes of this Subsection 5.3 only, the following words and phrases shall have the following meanings:
 - i. "Allowable Expenses" means any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Health Benefit Plans covering the person for whom claim is made. When a Health Benefit Plan provides benefits in the form of coverage for services, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.
 - ii. "Health Benefit Plan" means any of the following which provide coverage for medical care or treatment:
 - (1) Coverage under government programs, including Medicare, required or provided by any statute unless coordination of benefits with any such program is forbidden by law.
 - (2) Group coverage or any other arrangement of coverage for individuals in a group whether on an insured or uninsured basis, including health maintenance organization or other form of group coverage; medical care components of group long-term care contracts; and medical benefits under group or individual automobile contracts.
 - (3) An individually underwritten accident and health insurance policy which reduces benefits because of the existence of other insurance.

- (4) Coverage under any automobile insurance policy, including but not limited to medical payment, personal injury protection or no-fault benefits.

The term "Health Benefit Plan" shall be construed separately with respect to:

- (1) Each Policy, contract or other arrangement for benefits or services.
 - (2) That portion of any such Policy, contract or other arrangement which reserves the right to take the benefits of other Health Benefit Plans into consideration in determining its benefits and that portion which does not.
- b. The Company shall have the right to coordinate benefits between this Plan and any other Health Benefit Plan covering a Covered Person.

The rules establishing the order of benefit determination between this Benefit Certificate and any other Health Benefit Plan covering the Covered Person on whose behalf a claim is made are as follows:

- i. The benefits of a Health Benefit Plan which does not have a "coordination of benefits with other health plans" provision shall in all cases be determined and applied to claims before the benefits of this Benefit Certificate.
 - ii. If according to the rules set forth in Subsection c. of this Section, the benefits of another Health Benefit Plan that contains a provision coordinating its benefits with this Plan would be determined and applied, before the benefits of this Plan have been determined and applied, the benefits of such other Health Benefit Plan will be considered before the determination of benefits under this Plan.
 - iii. Under no circumstances shall benefits payable and paid under this Plan together with any other Health Benefit Plans exceed the total charge for services a Covered Person received.
- c. **Order of Benefit Determination:** The order of benefit determination as to a Covered Person's claim shall be as follows:

- i. **Non-Dependent or Dependent.** The benefits of a plan which covers the person on whose expenses a claim is based other than as a dependent shall be determined and applied before the benefits of a plan which covers such person as a dependent. (By way of example only, if one Plan [Plan A] covers a person as a Policyholder or an employee and the other plan covers the person as a dependent of a Policyholder or of an employee [Plan B], then Plan A is deemed "primary" and Plan A's benefits will be applied and paid before any consideration of Plan B.)
- ii. **Child Covered Under More Than One Plan.** When the parents of a dependent child are married, the benefits of a plan which covers the person on whose expenses a claim is based as a dependent child of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a plan which covers such person as a dependent child of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If the other plan does not have the provisions of this paragraph regarding coverage of dependent children of married parents, or if both parents have the same birthday, the plan that has covered either of the parents longer is primary.

The following rules apply to determine the order of benefit determination for a dependent child of parents who are separated or divorced:

- (1) When the parents are separated or divorced and there is a court decree which fixes financial responsibility on one of the parents for the medical, dental, or other health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.

- (2) When the parents are separated or divorced and the parent with custody of the child has not remarried, if there is no court decree fixing financial responsibility on one of the parents for the medical, dental or other health care expense with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
 - (3) When the parents are divorced and the parent with custody of the child has remarried, if there is no court decree fixing financial responsibility on one parent for the medical, dental or other health care expense with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the step-parent, and the benefits of a plan which covers that child as a dependent of the step-parent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.
 - iii. **Active or Inactive Employee.** When paragraphs (i) or (ii) above do not apply so as to establish an order of benefits determination, the plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule set out in paragraph (i) above.
 - iv. **Continuation coverage.** When paragraphs (i), (ii) or (iii) above do not apply so as to establish an order of benefits determination, if a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, Covered Person, subscriber policyholder or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
 - v. **Longer or Shorter Length of Coverage.** When paragraphs (i), (ii), (iii) or (iv) above do not apply so as to establish an order of benefits determination, the plan that covered the person as an employee, policyholder, Covered Person, subscriber or retiree longer is primary.
 - vi. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of health benefit plan, Subsection 5.3.1.a.(ii). In addition, this plan will not pay more than it would have paid had it been primary.
- 2. **Medicare, Military or Government Benefits.** If a Covered Person is a Medicare beneficiary, benefits will be determined in accordance with the Medicare Secondary Payer rules. Services and benefits for treatment of military service-connected disabilities to which a Covered Person is legally entitled from a military or government benefit plan shall in all cases be provided before the benefits of this Benefit Certificate.
- 3. **Workers' Compensation.** There are no benefits under this Benefit Certificate for treatment of any injury which will sustain a claim for damages from Workers' Compensation. This regardless of whether or not the Covered Person filed a claim for workers' compensation benefits.

The Company will presume that if the Covered Person makes a claim for worker's compensation benefits, the injury for which the Covered Person makes any such claim is an injury which will sustain a claim for damages under the Workers' Compensation Law. Therefore, the Company will not be liable for payment of any benefits as to such a claim, unless the full Workers' Compensation Commission finds that the Covered Person's injury was not a compensable injury; and the finding is

not overturned on appeal. The foregoing presumption of non-coverage under this Benefit Certificate also applies to any case in which the Covered Person's workers' compensation benefits claim is settled by joint petition or otherwise. In this case, no benefits will be paid under this Benefit Certificate with respect to such a claim, regardless of the settlement amount.

Nor will the Company pay benefits for injury or illness for which the Covered Person receives any benefits under the Workers' Compensation Law, state or federal workers' compensation, employer's liability or occupational disease law, or motor vehicle no-fault law, regardless of any limitations in scope or coverage amount which may apply to the Covered Person's benefits claim under such laws.

In the event that the Company pays any claim by the Covered Person for benefits under this Benefit Certificate, and subsequently learns that the Covered Person has filed a claim for workers' compensation benefits as to such claim, or that the Covered Person has settled a workers' compensation claim with any workers' compensation carrier, or has otherwise received any amount toward payment of such a claim under the Workers' Compensation Law, state or federal workers' compensation, employer's liability or occupational disease law, or motor vehicle no-fault law, the Covered Person agrees to reimburse the Company to the full extent of its payments on such claim.

4. **Acts of Third Parties (Subrogation/Reimbursement).** If a Covered Person is injured by a third party, the Company is subrogated to all rights the Covered Person may have against any party liable for payment of medical treatment (including any and all insurance carriers) to the extent of payment for the services or benefits provided as allowed by law. The Covered Person must cooperate fully with the Company in its efforts to collect from the third party. See Subsection 5.3.5. The Covered Person must cooperate fully with the Company in its efforts to collect from the third party. The Company may assert its subrogation rights independently of the Covered Person. In addition to the above-referenced subrogation rights, the Company also has reimbursement rights should the Covered Person, or the legal representative, estate or heirs of the Covered Person recover damages by settlement, verdict or otherwise, for an accident, injury or illness. If a recovery is made, the Covered Person shall promptly reimburse the Plan any monetary recovery made by the Covered Person and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payments coverage, direct recoveries from liable parties, or any other source.
5. **Covered Person's Cooperation.** Each Covered Person shall complete and submit to the Company such consents, releases, assignments and other documents as may be requested by the Company in order to obtain or assure reimbursement from other health benefit plan(s), from Medicare, from Workers' Compensation, or through subrogation. Any Covered Person who fails to so cooperate will be liable for and agrees to pay to the Company the amount of funds the Company had to expend as a result of such failure to cooperate, and the Company shall be entitled to withhold coverage of or offset future claim payments for benefits, services, payments or credits due under this Benefit Certificate in order to collect the Covered Person's liability resulting from his or her failure to cooperate.
6. **The Company's Right to Overpayments.** Whenever payments have been made by the Company in a total amount, at any time, in excess of 100% of the amount of payment necessary at that time to satisfy the intent of this Benefit Certificate, the Company shall have the right to recover such payment, to the extent of such excess, from among one or more of the following as the Company shall determine: any person or persons to, or for, or with respect to whom, such payments were made; any insurance Company or companies; or any other organization or organizations to which such payments were made.

6.0 ELIGIBILITY STANDARDS

Even if a Health Intervention you receive would be covered under the other coverage standards of this document, you still must be eligible for benefits under your Plan and your coverage must be in effect at the time you receive such Intervention in order to receive benefits. This Section sets out the standards for eligibility under the Plan, Subsection 6.1; the policies for determining a Covered Person's effective date, Subsection 6.2; policies governing termination of coverage, Subsection 6.3; the options a person who has lost eligibility may have under state and federal law to

continue coverage under the Plan, Subsection 6.4; and the rights a person who has lost eligibility may have to receive a Conversion Plan from the Company, Subsection 6.5.

6.1 **Eligibility for Coverage.** The following provisions outline the eligibility requirements for Employees and Dependents. In order to be covered by the Benefit Certificate, you must meet the eligibility requirements for an Employee or the Employee's Dependent.

1. **Employee Coverage.** To be eligible, an Employee must
 - a. Be a Qualified Employee of the Qualified Employer Policyholder, or
 - b. Be an employee of the Policyholder who
 - i. works on a full-time basis for the Policyholder;
 - ii. has completed the required Waiting Period, if applicable;
 - iii. is in a class of Employees who are included in the Plan; and
 - iv. work at least thirty (30) hours per week and forty-eight (48) weeks per year.
2. **Dependent Coverage.** Eligible Dependents are the Employee's:
 - a. Spouse;
 - b. Child less than 26 years of age.
 - c. unmarried Child who is incapable of self-support because of intellectual and developmental disability or physical disability, provided (1) such Child is or was under the limiting age of dependency stated in Subsections b. above at the time of application for coverage in the Plan or (2) if not under such limiting age, has had continuous health plan coverage, i.e., no break in coverage greater than 63 days, at the time of application for coverage in the Plan.

NOTE: Domestic partners are not eligible for coverage as Dependents under this Benefit Certificate.

3. **Additional Eligibility Requirements for Dependent Coverage.** In order for an Employee's Dependent to be eligible for coverage:
 - a. the Employee must be eligible for and have coverage; and
 - b. the Dependent must not be in active military service.
4. **Proof of Intellectual and Developmental Disability or Physical Disability.** In order for Dependent coverage to be provided due to intellectual and developmental disability or physical disability, proof of the Child's dependency and disability must be furnished to the Company, or to the Exchange if the Policyholder is a Qualified Individual, prior to the Child's attainment of the applicable limiting age referenced in section 6.1.3.b., above. Such proof must at least demonstrate that the Child is unable to obtain or continue a job or position in the course of commerce and that his or her parent(s) are providing 50% or more of his financial support (e.g., declaring the Child as a dependent on their federal income tax return or providing a child's birth certificate.) Initial and subsequent evaluation for continued intellectual and developmental disability or physical disability and dependency may be required by the Company, at the Company's expense, or the Exchange if the Policyholder is a Qualified Individual, but not more frequently than once per year. A Policyholder who first becomes eligible under the Plan may enroll a disabled Dependent Child provided the intellectual and developmental disability or physical disability commenced before the limiting age.
5. **Military Duty.** If a Covered Person is called to active duty in the armed services of the United States of America, the Covered Person's (and any covered dependents) coverage may be continued on COBRA for a period of 18 months or under the Uniformed Services Employment and Reemployment Rights Act (USERRA) for a period of 24 months. However, the Covered Person must elect to continue coverage under USERRA within sixty days of activation. A former Covered Person returning from active military service may enroll in the Plan within 90 days of his or her return to employment, provided the Employer continues to sponsor the Plan and payment of premium is timely made. The effective date of coverage for the employee returning from active military service will be the first day

of reemployment. The Company may require a copy of the returning member's orders terminating the active duty or other proof of the active duty or termination date thereof.

6.2 **Effective Date of Coverage.** The following provisions outline the Company's policies relative to effective dates of coverage for you and/or your dependents.

1. **Application and Effective Date.** In order for an Employee's coverage to take effect, the Policyholder must submit Eligibility Data for Employees and Dependents. If the Policyholder is a Qualified Employer that purchased this Benefit Certificate through the Small Business Health Options Program (SHOP,) the Policyholder shall submit this data to the Exchange. If the Policyholder purchased this Benefit Certificate directly from the Company, the Policyholder shall submit this Eligibility Data to the Company by written enrollment forms or through the Electronic Data Exchange Enrollment mechanism. The effective date(s) of coverage shall be determined in accordance with this Subsection 6.2 and indicated by the Company on the ID card, Schedule of Benefits or letter issued to Covered Persons by the Company.
2. **Employees and Dependents on Contract Effective Date.** Coverage under this Benefit Certificate shall become effective on the Group Contract Effective Date, for all Employees, and Dependents for whom Eligibility Data is submitted and premium is paid during the enrollment period prior to the Group Contract effective date.

Coverage will be extended to an eligible Employee or Dependent who is an inpatient in a Hospital on the effective date.
3. **Initial Enrollment of New Employees.**
 - a. If the Company receives a new Qualified Employee's Eligibility Data from the SHOP, the Employee's coverage will become effective 12:01 a.m. on the first day of the following Policy Month.
 - b. If the Company receives a new Employee's Eligibility Data directly from the Employer within thirty (30) days of the date the Employee is first eligible for coverage, the Employee's coverage will become effective 12:01 a.m. on the first day of the Policy Month following the date the Employee is first eligible for coverage. However, if the date the Employee is first eligible for coverage falls on the first day of the Policy Month, the Employee's coverage will become effective at 12:01 a.m. on that day.
4. **Coverage in the Case of Late Enrollment.** If an Employee or an Employee's Dependent's Eligibility Data is not submitted when such Employee or Dependent is initially eligible for coverage, the Employee or Dependent cannot subsequently obtain coverage, except during a Special Enrollment Period or during an Open Enrollment Period.
5. **Open Enrollment Period.** Annually, during a period of at least 30 days designated by the Employer, or by the SHOP in the case of Qualified Employers, Employees who are eligible for coverage may enroll in the Plan. During the Open Enrollment Period, Employees covered in the Plan may change their coverage, and that of their covered dependents. Unless otherwise designated in this Benefit Certificate, enrollments and coverage changes made during the Open Enrollment Period become effective on the anniversary date of the Group Policy.
6. **Effective Date for Existing Dependents.** If the Employee has eligible Dependents on the date the Employee's coverage begins, the Employee's Dependents' coverage will begin on the Employee's effective date if:
 - a. The Policyholder or the SHOP, if the Policyholder is a Qualified Employer, submits Eligibility Data for the Employee's Dependents' coverage within 30 days of the Employee's effective date; and
 - b. The appropriate premium is timely paid.
7. **Initial Effective Date for Newly Acquired Dependents.** If an Employee acquires a new eligible Dependent after the date the Employee's coverage begins, coverage for a new Dependent will become effective in accordance with the following provisions:

- a. **Spouse.** When an Employee marries and wishes to have the Employee's Spouse covered, the Policyholder shall submit Eligibility Data within 30 days of the date of marriage. The effective date will be the first of the month following the date of marriage. If the Policyholder submits Eligibility Data after the 30-day period, coverage for the Spouse will become effective in accordance with the provisions for Late Enrollment. See Subsection 6.2.4, above.
 - b. **Newborn Children.** Coverage for an Employee's newborn Child shall become effective as of the Child's date of birth if the Policyholder gives the Company notice by submitting Eligibility Data to the Company for the Child within 90 days of the Child's date of birth and the appropriate premium to cover the newborn Child from the date of birth is paid. If the Policyholder submits the Eligibility Data after the applicable 90-day time period, coverage for the Employee's newborn Child will become effective in accordance with the provisions for Late Enrollment. See Subsection 6.2.4, above.
 - c. **Qualified Medical Child Support Order.** If a court has ordered an Employee to provide coverage for a Child, coverage will be effective on the first day of the month following the date the Company receives notification of the court order and the Child's Eligibility Data from the Policyholder or the SHOP if the Policyholder is a Qualified Employer. In the event a court has ordered an Employee of the Employer who is not covered by the Plan to provide coverage for a child, the Employee shall be enrolled with the child as a Dependent. The Child's enrollment will become effective on the first day of the month following the Company's receipt of the Child's Eligibility Data.
 - d. **Newly Adopted Children.** Subject to payment of all applicable premiums, coverage for a Child placed with an Employee for adoption or for whom the Employee has filed a petition for adoption, shall begin on the date the Child is placed for adoption or the date of the filing of the petition for adoption, provided Eligibility Data for the Child's coverage is submitted to the Company within 60 days after the placement or the filing of the petition. The coverage shall begin from the moment of birth if the petition for adoption or placement for adoption occurred and the Eligibility Data for coverage is submitted to the Company within 60 days of the Child's birth. If the Policyholder submits the Eligibility Data after such 60-day period, coverage for the adopted Child will become effective in accordance with the provisions for Late Enrollment. See Subsection 6.2.4, above. The coverage shall terminate upon the dismissal, denial, abandonment or withdrawal of the adoption, whichever occurs first.
 - e. **Other Dependents.** Eligibility Data for enrollment received by the Company within 30 days of the date that any other dependent first qualifies as an eligible Dependent will result in coverage for such dependent on the first day of the month following the date that Eligibility Data for coverage is received by the Company. Such Dependent will not be a Late Enrollee. If the Policyholder submits the Eligibility Data after the 30-day period, coverage for the Dependent will become effective in accordance with the provisions for Late Enrollment. See Subsection 6.2.4, above.
8. **Employee's Effective Date Controls.** In no event will a Dependent's coverage become effective prior to the Employee's Effective Date.
9. **Special Enrollment Period** is the 30-day period during which time an Employee or Dependent may enroll in the Plan, after his or her initial Eligibility Date or Open Enrollment Period and not be a Late Enrollee. Special Enrollment Periods occur in the following instances:
- a. A Dependent of the Employees loses Minimum Essential Coverage under another health plan for reasons other than failure to pay premiums or justified rescission.
 - b. The Employee gains a Dependent through marriage, birth, adoption or placement for adoption. Note that the Special Enrollment Period for an adopted child is 60 days and for a newborn child is 90 days.
 - c. A Dependent of the Policyholder that is a Qualified Employee who was not previously a citizen, national or lawfully present becomes a Qualified Individual by gaining the applicable status.

10. **Medicaid or State Child Health Insurance Program (“CHIP”) Special Enrollment Period** is a 60-day period during which time an Employee or Employee’s dependent may enroll in the Plan, after his or her initial Eligibility Date and not be a Late Enrollee. Medicaid or CHIP Special Enrollment Periods occur **ONLY** in two instances:
- a. **After the Termination of Medicaid or CHIP Coverage.** A Medicaid or CHIP Special Enrollment Period begins on the day an employee’s or dependent’s coverage under Medicaid or CHIP terminates as a result of Loss of Eligibility.
 - b. **After Eligibility for Employment Assistance under Medicaid or CHIP.** A Medicaid or CHIP Special Enrollment Period occurs for an employee or employee’s dependent who becomes eligible for assistance, with respect to coverage under group health plans or health insurance plans under Medicaid or CHIP (including under any waiver or demonstration project conducted under or in relation Medicaid or CHIP).

6.3 **Termination of Coverage.** The following provisions outline the Company’s policies relative to termination of coverage for the Policyholder, you and/or your dependents.

- 1. **Termination of Coverage.** Coverage is subject to all terms and conditions of the Plan, and coverage will terminate under certain conditions described in various other places throughout this document. If coverage is not terminated under any other provision of this document, coverage for a Covered Person shall terminate if any of the following events occur:
 - a. Coverage shall terminate at 12:00 midnight Central time on the date of event when:
 - i. This Plan terminates.
 - ii. The Employer to which the Group Policy is issued, terminates or ceases to sponsor the Plan.
 - b. Coverage shall terminate at 12:00 midnight Central Time on the last day of the Policy Month in which the event occurs when:
 - i. The Covered Person ceases to be eligible as an Employee or Dependent for any reason.
 - ii. The Covered Person is a Dependent Spouse who becomes legally separated or divorced from the Employee.
 - c. Any Covered Person’s coverage shall terminate at 12:00 midnight Central Standard Time on the last day of the applicable premium period for which premium was paid if premium is not paid on or before the next premium due date.
- 2. **Termination of a Covered Person’s Coverage for Cause.**
 - a. **Bases for Termination.** The Company may terminate coverage under this Benefit Certificate, including termination by rescission of all coverage retroactive to the Covered Person’s original effective date, upon thirty (30) days’ written notice for:
 - i. intentional misrepresentation of material fact or fraud in obtaining coverage or
 - ii. Intentional misrepresentation of material fact or fraud in the filing of a claim for services, supplies or in the use of services or facilities
 - b. **Concealment or Misrepresentation.** For purposes of this termination for cause provision, intentional misrepresentation of material facts occurs if (i) information is withheld or if incorrect information is provided that is material to the risk assumed by the Company, or (ii) the Company would not have issued this Benefit Certificate, would have charged a higher premium, or would not have paid a claim in the manner it was paid had the Company known the facts concealed or misrepresented.
 - c. **Termination Effective Date.** Rescission of coverage shall become effective on the Covered Person’s original effective date. If the Company elects to terminate the coverage other than by rescission, the termination shall be effective upon the later of (i) thirty (30) days after a

written notice of termination for cause is posted in the U.S. Mail, addressed to the Covered Person at his or her last known address as provided by the Covered Person to the Company; or (ii) the date stated in the termination notice letter to Covered Person.

- d. **Appeal Procedure.** A Covered Person may appeal a termination for cause. Such an appeal must be submitted in writing, addressed to the Appeals Coordinator of Arkansas Blue Cross and Blue Shield, 601 S. Gaines Street, Little Rock, Arkansas 72203. In order for the appeal to be considered the Appeals Coordinator must receive the appeal prior to the later of (i) thirty (30) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Covered Person at his or her last known address as provided by Covered Person to Company; or (ii) the termination effective date stated in the termination notice letter to Covered Person.
3. **Premium Refunds.** If the Company terminates the coverage of a Covered Person, premium payments received on account of the terminated Covered Person applicable to periods after the effective date of termination shall be refunded to the Employer within 30 days, and the Company shall have no further liability under this Group Policy.

If the Employer terminates coverage of a Covered Person, the Employer must request the Company refund premiums paid for such Covered Person's coverage within 60 days from the effective date of termination of such coverage. Failure of the Employer to make a refund request within 60 days of the effective date of termination of the Covered Person's coverage shall result in the Employer waiving refund of any premiums paid for such coverage. If claims have been paid past the termination date, the payment amount of the claims will be deducted from premium refunds.
4. **Termination of the Group Contract, Impact on Covered Persons.** The coverage of all Covered Persons shall terminate if the Group Contract is terminated.

6.4 Continuation Privileges

1. **Continuation of Hospital Benefits When Group Contract is Replaced.** If a Covered Person is hospitalized on the date the Group terminates coverage with the Company and replaces the coverage with another company, coverage for the Covered Person will continue until the date the Covered Person is discharged or until benefits under the Plan are exhausted, whichever occurs first.
2. **Continuation Rights under State Law**
 - a. If a Covered Person's employment terminates or dependency status changes the Covered Person shall have the right under state law to elect continuation of coverage under the Plan as outlined below. In order to be eligible for this option, Covered Person must:
 - i. have been continuously covered under this Benefit Certificate for at least three (3) consecutive months prior to employment termination or change in dependency status; and
 - ii. make the election by notifying the Company in writing no later than ten (10) days after the employment termination or change in dependency status.
 - b. Continuation shall terminate on the earliest of:
 - i. one hundred twenty (120) days after the date the election is made;
 - ii. the date the Covered Person fails to make any premium payments or the Policyholder fails to pay the premium to the Company;
 - iii. the date the Covered Person is or could be covered by Medicare;
 - iv. the date on which the Covered Person is covered for similar benefits under another group or individual Policy;
 - v. the date on which the Covered Person becomes eligible for similar benefits under another group Plan;
 - vi. the date on which similar benefits are provided for or available to the Covered Person

- under any state or federal law; or
 - vii. the date on which the Group Policy terminates.
 - c. If a Covered Person qualifies for continuation of coverage, the Covered Person may elect a conversion policy instead of continuation of group insurance. See Section 6.5 Conversion Privileges. If a Covered Person has elected continuation under this Subsection 6.4.2, the Covered Person shall have the option of conversion coverage at the end of the maximum continuation period.
- 3. **Continuation Rights under Federal Law.** If Section 10001 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to the Group, the coverage of an Employee or Dependent whose coverage ends due to a Qualifying Event may be continued while the Group Contract remains in force subject to the terms of this Section and all terms and provisions of this Benefit Certificate not inconsistent with this Section.

This provision shall not be interpreted to grant to any Covered Person any continuation rights under this Benefit Certificate in excess of those required by COBRA. If the Group fails to comply with the provisions of the Group Policy and this Benefit Certificate concerning COBRA or the notice requirements or other standards under COBRA, the Company shall not assume the Group's obligation to provide COBRA continued coverage under the Plan.

- a. **Qualifying Events.** The following is a list of events which could result in termination of a Covered Person's coverage under this Benefit Certificate. If such should occur, for purposes of this Section, the event shall be called a Qualifying Event.
 - i. An Employee's death.
 - ii. Termination of an Employee's employment (other than by reason of the Employee's gross misconduct), or of an Employee's eligibility due to reduction in the Employee's hours of employment.
 - iii. An Employee's and Spouse's divorce or legal separation.
 - iv. An Employee becoming entitled to Medicare.
 - v. A Dependent Child ceasing to be a Dependent Child as defined in this Benefit Certificate.
- b. **Requirements for COBRA Continuation.** Continuation under this Subsection is subject to a Covered Person requesting it and paying any required premium contributions to the Group within the applicable COBRA election period. In addition, all of the following conditions must be satisfied in order for COBRA continuation coverage to apply:
 - i. The Group must sponsor and maintain the Plan at the time of the qualifying event, as well as when the Covered Person elects to continue coverage; and
 - ii. The Group, as Plan Administrator, must have provided the Covered Person an initial notice of COBRA rights at the time coverage commenced under the Plan (this Benefit Certificate); and
 - iii. The Plan Administrator must notify the person qualified to elect continuation of coverage under COBRA ("Qualified Insured") of the right to elect coverage within 14 days of receiving notice of the happening of any of the qualifying events listed above; and
 - iv. The Covered Person must notify the Plan Administrator within 60 days of the happening of Qualifying Event (iii) or (v) in Section 6.4.3.a, above; and
 - v. The Covered Person must elect to continue coverage under the Plan within 60 days of the later of:
 - (1) the date the notification of election rights is sent, or
 - (2) the date coverage under the Plan terminates.

If an election is not made by the Covered Person within this 60-day period, the option to elect COBRA shall end.

If an Employee with Dependent coverage requests continuation of coverage under this Section, such request shall include the Dependent coverage, unless the Employee asks that it be dropped. In like manner, such a request on the part of the covered Spouse of a Covered Person shall include coverage for all Dependents of the Employee who were covered.

- c. **Coverage Continued.** The coverage continued for a Covered Person in accordance with this Section shall be the same as otherwise provided under this Benefit Certificate for other Covered Persons in the same benefit class in which such Covered Person would have been covered had his or her coverage not terminated.
- d. **Effective date.** The effective date for COBRA continuation is the date coverage under the Plan terminates due to a qualifying event.
- e. **Termination.** Once in effect, COBRA continuation coverage for a Covered Person under this Section shall terminate on the earliest to occur of the following applicable dates:
 - i. The date the Group Contract terminates;
 - ii. At the end of the last period for which premium contributions for such coverage have been made, if the Covered Person or other responsible person does not make, when due, the required premium contribution to the Group;
 - iii. The date ending the maximum period. In the Case of Qualifying Event 6.4.3.a.(ii) above (relating to termination of employment or reduction in hours), the date ending the maximum period shall be the date 18 months after the date of that Qualifying Event; unless the Social Security Administration determines that the Covered Person is disabled at the time of or within 60 days after the Qualifying Event, and the Covered Person provides the notice of Social Security disability determination to the Plan Administrator within 60 days of the date of the Social Security determination and before the end of the initial 18-month period of continuation, in which case this date shall be 29 months after the Qualifying Event. In all other cases, such date shall be the date 36 months after the date of the applicable Qualifying Event;
 - iv. The date the Covered Person becomes covered under any other group health plan that provides coverage for Preexisting Conditions;
 - v. The date the Covered Person becomes entitled to Medicare;
 - vi. The date the Covered Person's coverage is terminated for cause. See Section 6.3.2 above.

6.5 Conversion Privileges

- 1. **Eligibility.** If a Covered Person's coverage under the Plan terminates for any reason other than
 - a. failure to pay any sum required by the Group toward the cost of coverage under this Benefit Certificate, if any, or
 - b. cause (see Section 6.3.2) or,
 - c. the Group Contract being replaced by a health benefit plan provided by an organization other than the Company, then the Covered Person may apply for an insurance policy issued by the Company on the individual market if
 - i. the Covered Person is not eligible for Medicare coverage; or
 - ii. the Covered Person is not eligible for coverage under any other group health plan that provides coverage for Preexisting Conditions.
- 2. **Benefits.** The insurance policy will be provided by the Company at the rates in effect on the date the Covered Person submits his or her application. The benefits in the individual policy will not

necessarily equal or match those benefits provided in the Group Contract. No evidence of good health or insurability will be required to affect the conversion.

3. **Written Application Deadline.** In order to obtain an individual policy, written application and payment of applicable premium charges must be submitted to the Company within 60 days following the date on which the Company sends the Covered Person a notice of termination of coverage.

7.0 CLAIM PROCESSING AND APPEALS

In reviewing a claim for benefits, the Company will apply the terms, conditions, exclusions and limitations of the Plan set out in this Benefit Certificate, including but not limited to the Primary Coverage Criteria, Section 2.0; the specific limitations of the Plan, Section 3.0; the specific plan exclusions, Section 4.0; the cost sharing and Provider network procedures of the Plan, Section 5.0; and the eligibility standards of the Plan, Section 6.0.

This Section 7 sets out the procedures you must follow in submitting a request for coverage, called a "claim for benefits" or a "claim," with your Plan, Subsection 7.1. The section also describes your rights to appeal if a claim for benefits is denied either in whole or in part, Subsections 7.2 and 7.3. Finally, this section sets out how you may have an Authorized Representative to represent you in submitting claims or appeals, Subsection 7.4.

7.1 Claim Processing.

1. **Claim for Benefits.** "Claim for benefits" means (1) a request for payment for a service, supply, prescription drug, equipment or treatment covered by the Plan or (2) a request for Prior Approval for a service, supply, prescription drug, test, equipment or treatment covered by the Plan where the Plan conditions receipt of payment for such service, supply, prescription drug, equipment or treatment on approval in advance by the Company.
2. **Who May Submit a Claim.** A Covered Person, a Provider with an assignment of the claim that is approved by the Company or the Covered Person's Authorized Representative may submit a claim. See Subsection 7.4 below concerning the Authorized Representative.
3. **Classifications of Claims.** There are two general types of claims for benefits possible under the Plan. The type of claim involved affects the procedures for filing the claim and the timing of the benefit determination by the Company.
 - a. **Post-Service Claims.** The most common claim involves post-service benefit determination. Such a claim results when a Covered Person obtains a medical service, prescription drug, supply, test, equipment or other treatment and then, in accordance with the terms of the Plan, the Covered Person or the Covered Person's Authorized Representative submits a claim for benefits to the Company. Examples of post-service claims are claims involving physician office visits, maternity care, outpatient services, and most prescription drugs obtained through a managed pharmacy benefit.

You must submit written proof of any service, supply, prescription drug, test, equipment or other treatment within 180 days after such service, supply, prescription drug, test, equipment or treatment was received. In the case of a claim for inpatient services for multiple consecutive days, the written proof must be submitted no later than 180 days following your date of discharge for that single admission.

Post-Service Claims may be submitted electronically in accordance with the Company's electronic claim filing procedures, or such claims may be mailed to Arkansas Blue Cross and Blue Shield Claims Division, Post Office Box 2181, Little Rock, Arkansas 72203.

If the Company is able to process your post-service claim without requesting additional information, it will notify you of its claim determination within 30 days of the Company's receipt of the claim. The Company will forward any payment resulting from the claim determination within 30 days of the Company's receipt of the claim.

If the Company requires information reasonably necessary to determine whether or to what extent benefits are covered under the Plan, as specified in Subsection 7.1.4. below, the Company will suspend the claim and request the needed information. If you or your treating

Provider supplies the Company the required information within ninety (90) days of the claim suspension, the Company will notify you of its claim determination and will forward any payment resulting from the claim determination within 15 days of the Company's receipt of the required information. If the Company does not receive the required information within the 90-day period, 15 days later, the suspended claim becomes a denied claim, subject to appeal. See Subsection 7.2 Claim Appeals to the Plan.

- b. **Pre-Service Claims.** The terms of the Plan condition receipt of certain benefits on Prior Approval by the Company, whereby the Company gives approval in advance of the Covered Person obtaining a requested medical service, drug, supply, test, or equipment that such medical service, drug, supply, test, or equipment meets Primary Coverage Criteria. Plan benefits requiring pre-service claims are claims for certain Prescription Medications (Subsection 3.24) and, Non-PPO Benefits (Subsection 5.1.3), **(Please note Prior Approval does not guarantee payment or assure coverage, it means only that the information furnished to the Company in the pre-service claim indicates that the Health Intervention meets the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0) All Health Interventions must still meet all other coverage terms, conditions, and limitations, and coverage for these services may still be limited or denied if, when the post-service claim for the services is received by Us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention, that the Covered Person ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Benefit Certificate.**

Pre-service claims for medical Health Interventions may be submitted to the Arkansas Blue Cross and Blue Shield by (1) calling the Customer Service telephone number found on the reverse side of your Arkansas Blue Cross ID Card, (2) sending an email to PRESERVICEBENEFITINQUIRY@ARKBLUECROSS.COM, (3) submitting the pre-service claim to Arkansas Blue Cross Medical Audit and Review Services, FAX (501) 378-6647, or (4) mailing the claim to Post Office Box 3688, Little Rock, Arkansas 72203. Pre-service claims for Prescription Medications should be submitted to Arkansas Blue Cross and Blue Shield Managed Pharmacy, FAX (501) 378-6980, or mailed to Post Office Box 2181, Little Rock, Arkansas 72203.

If the Company is able to process your pre-service claim without requesting additional information, it will notify you of its determination in a time appropriate for the medical exigencies, but in no case later than 2 business days from the date it received the pre-service claim.

If the Company requires information reasonably necessary to determine whether the requested medical service, drug, supply, test or equipment meets the Primary Coverage Criteria under the Plan, the Company will suspend the claim and request the needed information. If you or your treating Provider supplies the Company the required information within ninety (90) days of the claim suspension, the Company will notify you of its claim determination within 2 business days after the Company receives such information. If the Company does not receive the required information within the 90-day period, 15 days later, the suspended claim will become a denied claim, subject to appeal. See Subsection 7.2. Claim Appeals to the Plan.

After you have received the Health Intervention that was the subject of an approved pre-service claim, you must submit a post-service claim in accordance with Subsection 7.1.3.a., above.

- c. **Provider Initiated Pre-Service Claims.** A Provider treating a Covered Person may initiate a pre-service claim to obtain an initial determination for a medical service, drug, supply, test, or equipment covered by the Plan when the Plan does not condition receipt of such medical service drug, supply, test, or equipment on Prior Approval. Pre-service claims should be

submitted to the Arkansas Blue Cross and Blue Shield Medical Audit and Review Services, FAX (501) 378-6647 or mailed to Post Office Box 3688, Little Rock, Arkansas 72203. Pre-service claims for Prescription Medications should be submitted to Arkansas Blue Cross and Blue Shield Managed Pharmacy, FAX (501) 378-6980, or mailed to Post Office Box 2181, Little Rock, Arkansas 72203.

If the Company is able to process the Provider initiated pre-service claim without requesting additional information, the Company will notify the treating Provider of its determination within 10 days from the date it received the pre-service claim.

If the Company requires information reasonably necessary to determine whether the requested medical service, drug, supply, test, or equipment meets the Primary Coverage Criteria under the Plan, the Company will suspend the claim and request the needed information. If the treating Provider supplies the Company the required information within ninety (90) days of the claim suspension, the Company will notify the treating Provider of its claim determination within 10 days after the Company receives such information. If the Company does not receive the required information within the 90-day period, 15 days later, the suspended claim will become a denied claim, subject to appeal. See Subsection 7.2. Claim Appeals to the Plan.

After the Provider has performed the Health Intervention the Health Intervention that was the subject of an approved Provider initiated pre-service claim, the treating Provider must submit a post-service claim in accordance with Subsection 7.1.3.a., above.

- d. **Claims Involving Urgent Care.** A claim involving urgent care must be a pre-service claim (See Subsection 7.1.3.b. above) for which a health care professional with knowledge of the claimant's condition certifies that the processing of the claim in the time period for making a non-urgent pre-service claim determination (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to maintain or regain maximum function, or (2) would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

A claim involving urgent care must be submitted in writing, via mail, facsimile or e-mail, in a format authorized by the Company's claim filing procedures. **A claim involving urgent care must include the medical records pertinent to the urgent condition.**

If the Company is able to process your claim involving urgent care without requesting additional information, it will notify you of its determination in a time appropriate for the medical exigencies, but in no case later than 1 business day from the date it received the pre-service claim.

If the Company requires information reasonably necessary to determine whether the requested medical service, drug, supply, test or equipment meets the Primary Coverage Criteria under the Plan, the Company will notify your physician within 24 hours of receiving the claim and request the needed information. If you or your treating Provider supplies the Company the required information within 48 hours, the Company will notify you of its claim determination within 1 business day after the Company receives such information. If the Company does not receive the required information within the 48-hour period, the claim will be denied, subject to appeal. See Subsection 7.3 Claim Appeals to the Plan.

If the urgent care claim is a request to extend previously approved benefit for ongoing treatment, the Company shall make a determination within 24 hours after receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the previously approved benefit.

Please note that approval of a claim involving urgent care does not guarantee payment or assure coverage; it means only that the information furnished to the Company at the time indicates that the Health Intervention that is the subject of the claim involving urgent care meets the Primary Coverage Criteria and is not subject to a Specified Plan Exclusion (see Section 4.0) A Health Intervention receiving prior approval as a claim

involving urgent care, must still meet all other coverage terms, conditions, and limitations. Coverage for any such claim may still be limited or denied if, when the claimed Intervention is completed and the Company receives the post-service claim(s), investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the prior approved claim and the actual Health Intervention, that the Covered Person ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Benefit Certificate applies to limit or exclude the claim.

After you have received the Health Intervention that was the subject of a claim involving urgent care, you must submit a post-service claim in accordance with Subsection 7.1.3.a., above.

- e. **Claims Involving Ongoing Care or Concurrent Review.** The Company's termination or reduction of a previously granted benefit under the Plan (other than by Plan amendment or termination) results in a claim involving ongoing care or concurrent review. The Company shall give an explanation of the reduction or termination of a benefit to the Covered Person, as specified in Subsection 7.1.6, with sufficient time prior to the termination or reduction to allow for an appeal under Subsection 7.2.8.d., to be completed before the termination or reduction takes place but no later than 24 hours after receipt of the claim.

4. Information Reasonably Necessary to Process a Claim.

- a. In order to be a claim, the submission must comply with the filing and coding policies and procedures established by the Company. You may request a copy of the claim coding policies and procedures from the Company or from your Provider. If the submission fails to comply with the claim filing or code policies or procedures, the Company shall return the submission to the person that submitted it. If the claim involved is a pre-service claim, the submission shall be returned as soon as possible, but no later than 5 days (24 hours for a claim involving urgent care), and the Company shall indicate on the returned submission the proper procedures to be followed.
- b. In addition to the claim completed in accordance with the Company's claim filing procedures, depending upon the service, supply, prescription drug, equipment or treatment that is the subject of the claim, the Company may require one or more of the following items of information to enable the Company to determine whether or to what extent the claimed benefit is covered by the Plan:
 - i. Information in order to determine if a limitation or exclusion of the Plan is applicable to the claim, or
 - ii. Medical information in order to determine the price for a medical procedure, or
 - iii. Information in order to determine if the Covered Person who received the claimed services is eligible under the terms of the Plan, or
 - iv. Information in order to determine if the claim is covered by another health benefit plan, workers' compensation, a government supported program, or a liable third party, or
 - v. Information in order to determine the obligation of each health benefit plan or government program under coordination of benefits rules,
 - vi. Information in order to determine if there has been fraud or a fraudulent or material misrepresentation with respect to the claim;
 - vii. payment from the Policyholder of premiums that were delinquent at the time the claimed services were rendered.

- 5. **Covered Person's Responsibility with Respect to Claim Information.** Before any benefits can be paid, you agree, as a condition of coverage under the Plan, to authorize and direct any Provider

of medical services or supplies to furnish to the Company, its agents, or any of its affiliates, upon request, all records, or copies thereof, relating to such services or supplies. Further, as a condition of your coverage, you agree to authorize the release of such records to any third-party review person or entity, for purposes of medical review or second opinion surgery. Finally, as a condition of coverage, you agree to fully and truthfully respond to inquiries from the Company about your claim or condition, including, but not limited to, your other insurance coverage, third party liability, or workers' compensation benefits and to request that any Physician or other Provider respond to all such inquiries. You understand and agree that your failure to respond to inquiries from the Company or failure to cooperate fully to obtain information requested by the Company from your Physician or other health care Provider shall be, by itself, grounds for denial of benefits under the Plan.

6. **Explanation of Benefit Determination.** Upon making a determination of a claim, the Company will deliver to you the following information:
 - a. The specific reason or reasons for the determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount and a way that the Covered Person may learn the diagnosis and treatment codes and their descriptions);
 - b. Reference to the specific plan provision(s) on which the determination is based;
 - c. A description of any additional information necessary for the claim to be perfected and an explanation of why such information is necessary;
 - d. A description of the Plan's appeal process, see Subsection 7.2 below. If the claim involves urgent care, a description of the expedited appeals process, see Subsection 7.2.7.c., below;
 - e. If the determination was based in whole or in part on a Company Coverage Policy an explanation of how to obtain a copy of the Coverage Policy at no cost. See Subsection 2.4.1.f., above.
7. **Informal Claim Review.** If you have questions about an Explanation of Benefit Determination, you may contact Customer Service (Telephone toll free (800) 238-8379, or write Arkansas Blue Cross and Blue Shield, Customer Service, Post Office Box 2181, Little Rock, Arkansas 72203) and ask that the determination be reviewed. Customer Service will respond in like manner with answers to your request. This informal review is not an Appeal (see Subsection 7.2 below) nor a substitute for an appeal. Nor must you ask for an informal review in order to request an appeal.
8. **Informal Coverage Information.** From time to time, you or your Provider may want an indication whether a service, supply, prescription drug, equipment or treatment is an eligible benefit of the Plan. You may make an Informal Coverage Information to Arkansas Blue Cross and Blue Shield Customer Service Division, Post Office Box 2181 Little Rock, Arkansas 72203, or by Telephone toll free (800) 800-4298.
 - a. An Informal Coverage Information is not a claim. You should understand that an Informal Coverage Information is different from a pre-service claim. In the case of an Informal Coverage Information the Plan does not specify that receipt of the benefit in question is conditioned upon Prior Approval of the Company (see Subsection 7.1.3.b., Pre-Service Claims, above).
 - b. **The Company's response to an Informal Coverage Information is not a guarantee of payment. The Company's ultimate determination of a claim will be based upon the relevant facts as applied to the terms, conditions, limitations and exclusions of the Plan.** An Informal Coverage Information is not a claim. The Company's response to an Informal Coverage Information is not a claim determination. The Company's response is based upon the information available to the Company at the time of the inquiry and such information may not be current or accurate. The Company reserves the right to make a final determination of the post-service claim resulting from a Health Intervention that may have been the subject of an Informal Coverage Information after the intervention has been completed and all relevant facts are known.

- c. An Informal Coverage Information is not subject to appeal.
 - d. A Provider wanting to know whether a service, supply, prescription drug, equipment or treatment meets the Primary Coverage Criteria and all other requirements for payment under the Plan should submit a Provider Initiated Pre-Service Claim. (See Subsection 7.1.3.c.)
9. **Covered Person’s Responsibility with Respect to Erroneous Claim Payments.** Despite our best efforts, we may make a claim payment which is not for a benefit provided under the Plan, or we may make payment to you when payment should have gone directly to the Provider of treatment or services instead. In the event of an erroneous or mistaken payment, you agree to refund the full amount of such payment to Us promptly upon our request. If the Company does not receive the full amount of the refund due, the Company will have the right to offset future payments made to you or your Provider under this Benefit Certificate or under any other Policy you have with the Company now or in the future.
10. **Out-of-Area Services** We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called “Inter-Plan Arrangements.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever you access healthcare services outside the geographic area we serve, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below. When you receive care outside of our service area, you will receive it from one of two kinds of providers. Most providers (“participating providers”) contract with the local Blue Cross and/or Blue Shield Plan in that geographic area (“Host Blue”). Some providers (“nonparticipating providers”) don’t contract with the Host Blue. We explain below how we pay both kinds of providers.
- a. **BlueCard[®] Program**
 - i. Under the BlueCard[®] Program, when you receive Covered Services within the geographic area served by a Host Blue, we will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers. When you receive Covered Services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:
 - The billed charges for Covered Services; or
 - The negotiated price that the Host Blue makes available to Us.
 - ii. Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.
 - iii. Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.
 - b. **Special Cases: Value-Based Programs**
 - i. *BlueCard[®] Program.* If you receive Covered Services under a Value-Based Program inside a Host Blue’s service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part

of such an arrangement, except when a Host Blue passes these fees to Us through average pricing or fee schedule adjustments.

- ii. **Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements.** If we have entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs on your behalf, we will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.
 - c. **Blue Cross Blue Shield Global Core.** If you are outside the United States (hereinafter “BlueCard service area”), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the provider. If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1-(800)-810-BLUE (2583) or call collect at 1-(804)-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.
 - i. **Inpatient Services.** In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact Us to obtain precertification for non-emergency inpatient services.**
 - ii. **Outpatient Services.** Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.
 - iii. **Submitting a Blue Cross Blue Shield Global Core Claim.** When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider’s itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Us, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-(800)-810-BLUE (2583) or call collect at 1-(804)-673-1177, 24 hours a day, seven days a week.
11. **Insurance Department.** Arkansas Blue Cross and Blue Shield is an insurance company regulated by the Arkansas Insurance Department. You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at: 1 Commerce Way, Suite 102, Little Rock, Arkansas 72202. You may also file an online complaint by visiting the Arkansas Insurance Department website at www.insurance.arkansas.gov.

7.2 Claim Appeals to the Plan (Internal Review).

1. **Legal Actions.** Prior to initiating legal action, you must file an appeal of your claim in accordance with this Subsection 7.2. No legal action shall be brought after the expiration of three (3) years from the time that a claim is required to be submitted.

2. **Who May Request a Review.** A Covered Person or the Covered Person's Authorized Representative may file an appeal to request a review of a claim denial. See Subsection 7.4 concerning the Authorized Representative.
3. **Where and When (Deadline) to Submit an Appeal.** If a claim for benefits is denied either in whole or in part, you will receive a notice explaining the reason or reasons for the denial. See Subsection 7.1.6, above. You may request a review of a denial of benefits for any claim or portion of a claim by sending a request marked "Appeal Request" to the Appeals Coordinator of Arkansas Blue Cross and Blue Shield, 601 S. Gaines Street, Little Rock, Arkansas 72203. Your request must be made within one hundred eighty (180) days after you have been notified of the denial of benefits.
4. **Appeals Subject to Direct External Review.** The Company may waive internal review of any claim determination. If the Company waives internal review, the Company shall defer the claim for external review in accordance with Section 7.3 below.
5. **Documentation.**
 - a. **Written Appeals.** You must submit your appeal in writing. However, an appeal related to a claim involving urgent care may initially be submitted orally. Although the Appeals Coordinator will immediately commence consideration of an oral appeal, the Appeals Coordinator requires written confirmation of the appeal.
 - b. **Appellant's Right to Information.** The Company shall provide you free of charge and sufficiently in advance of the date of the final internal adverse benefit determination to give you a reasonable opportunity to respond, reasonable access to, and copies of, all documents, records or other information that:
 - i. were relied upon in making the benefit determination;
 - ii. were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
 - iii. demonstrate compliance with the terms of the Plan.; or
 - iv. constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
 - c. **Appellant's Right to Submit Information.** You may submit with your request for review any additional written comments, issues, documents, records and other information relating to your claim.
 - d. **Appeals Coordinator Right to Information.** You and the treating health care professional are required to provide the Appeals Coordinator, upon request, access to information necessary to determine the appeal. Such information should be provided not later than five (5) days after the date on which the Appeals Coordinator's request for information is received, or, in the case of a claim involving urgent care or concurrent review, at such earlier time as may be necessary to comply with the applicable timelines. See Subsections 7.2.7.c. and d. Your failure to provide access to such information shall not remove the obligation of the Appeals Coordinator to make a determination on the appeal, but the Appeals Coordinator's determination may be affected if such requested information is not provided.
6. **Conduct of Review.**
 - a. **Scope of Review.** The Appeals Coordinator shall conduct a complete review of all information relating to the claim and shall not afford deference to the initial claim determination in conducting the review.
 - b. **Qualifications of Appeals Coordinator.** The Appeals Coordinator is an individual with appropriate expertise who is neither the individual who denied the claim that is the subject of the appeal, nor the subordinate of such individual.

- c. **Review of Medical Judgment.** When reviewing a claim in which the determination was based in whole or in part on medical judgment, including determinations with regard to the application of the Primary Coverage Criteria or a Coverage Policy, the Appeals Coordinator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall not be an individual that was consulted in the initial claim determination, nor the subordinate of such individual. The Appeals Coordinator shall, upon request, provide the identity of health care professional(s) consulted in conducting the review, without regard to whether the health care professional's advice was relied upon in making the benefit determination.
7. **Timing of Appeal Determination.**
- a. **Post-Service Claim.** The Appeals Coordinator shall render a decision on an appeal related to a post-service claim within a reasonable period of time, but notification of the Appeals Coordinator's determination shall be provided to you not later than sixty (60) days after the Appeals Coordinator received the appeal.
 - b. **Pre-Service Claim.** The Appeals Coordinator shall render a decision and provide notification of the decision on an appeal related to a pre-service claim in accordance with the medical exigencies of the case and as soon as possible, but in no case later than thirty (30) days after the date the Appeals Coordinator received the appeal, unless the pre-service claim involves hematology or oncology which requires a determination and notification within four (4) business days after the date the Appeals Coordinator received the appeal.
 - c. **Claims Involving Urgent Care.** If you request an expedited review, and a health care professional certifies that determination as a general pre-service claim would seriously jeopardize your life or health or your ability to regain maximum function, the Appeals Coordinator shall make a determination on review in accordance with the medical exigencies of the case and as soon as possible, but in no case later than seventy-two (72) hours after the time the Appeals Coordinator receives the request for review, unless the pre-service claim involves hematology or oncology which requires a determination and notification within two (2) business days after the date the Appeals Coordinator received the appeal. See Subsection 7.2.9., below.
 - d. **Concurrent Care Determination.** The Appeals Coordinator shall administer an appeal involving concurrent care in accordance with Subsections 7.2.7.a., b., or c., depending upon whether the claim is a post-service claim, a pre-service claim or a claim involving urgent care.
8. **Notification of Determination of Appeal to Plan.** The Appeals Coordinator shall provide notice of the review determination in a printed form and written in a manner calculated to be understood by the claimant. The notice shall include:
- a. The specific reason or reasons for the review determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount and a way that the Covered Person may learn the diagnosis and treatment codes and their descriptions);
 - b. reference to the specific plan provision(s) on which the review determination is based;
 - c. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information Relevant to the Claim for benefits;
 - d. a statement that any internal rule, guideline, protocol or other similar criterion relied upon by the Plan is available upon request and free of charge;
 - e. a statement describing the voluntary external review procedures offered by the Plan; and
 - f. a statement of the claimant's right to bring an action under the Employee Retirement Income Security Act of 1974.

9. **Expedited Appeal Procedure.** An appeal of a claim involving urgent care or of a claim involving ongoing care is conducted in accordance with this Subsection 7.2.9. Note that submission to the Appeals Coordinator may be done electronically, FAX No. (501) 378-3366, e-mail: APPEALSCOORDINATOR@ARKBLUECROSS.COM. In accordance with Subsection 7.2.5.a., an expedited appeal may be submitted by telephone, (501) 378-2025, followed by a written confirmation. Please refer to Subsection 7.2.5.d., with respect to submission of information concerning a claim involving urgent care or concurrent review to the Appeals Coordinator. In accordance with Subsection 7.2.7.c., the Appeals Coordinator will notify you and your treating health care professional of the determination of your expedited appeal in accordance with the medical exigencies of the case and soon as possible, but in no case later than 72 hours after the Appeals Coordinator receives the expedited appeal.

7.3 Independent Medical Review of Claims (External Review)

1. **Claim Appeals Subject to External Review.**
 - a. **Waiver of Internal Review.** If we have waived internal review, your appeal shall be to external review in accordance with this Section 7.3.
 - b. **Application of Primary Coverage.** If your claim has not been the subject of a prior external review and if we have denied your claim in whole or in part because the intervention did not meet the Primary Coverage Criteria (other than under the conditions outlined in Subsections 2.4.1.a., b., c. or d.) or because of the application of a Coverage Policy, you may request an independent medical review by an Independent Review Organization in accordance with the provisions of this Subsection 7.3 provided:
 - i. The claim denial was upheld in whole or in part as a result of the Plan's internal review process, or
 - ii. You have not requested or agreed to a delay in the Plan's internal review process and the Appeals Coordinator has not given you notification of the determination involving a pre-service claim appeal within thirty (30) days following receipt of your appeal to the Plan; or
 - iii. You have not requested or agreed to a delay in the Plan's internal review process and the Appeals Coordinator has not given you notification of the determination involving a post-service claim appeal within sixty (60) days following receipt of your appeal to the Plan; or
 - iv. Your claim meets the requirements for expedited external review, (see Subsection 7.3.13) and you have simultaneously submitted an appeal to the Plan.
2. **Where and When to Submit External Review Appeal.** A request for external review must be submitted on the forms provided by the Arkansas Insurance Department. You can obtain the forms by writing to the Arkansas Insurance Department, External Review, 1 Commerce Way, Suite 102, Little Rock, Arkansas 72202 or by calling (800) 852-5494. The forms are also available online at the Arkansas Insurance Department website at insurance.arkansas.gov. Your request must be made within four (4) months after you were notified that the claim denial was upheld in whole or in part as a result of the Plan's internal review process. If Subsection 7.3.1.b.ii. or 7.3.1.b.iii. apply, your request may be made at the end of the thirty (30) day period or sixty (60) day period. If Subsection 7.3.1.b.iv., applies, you must file your request for external review at the same time you file your appeal to the Plan.
3. **Independent Review Organization and Independent Medical Reviewer**
 - a. **The Arkansas Insurance Commissioner** shall determine if the claim is subject to external review, and if he or she so determines, assign an Independent Review Organization from the list of approved Independent Review Organizations compiled and maintained by the Commissioner.
 - b. **The Independent Review Organization** is not affiliated with, owned by or controlled by the Company. The Company pays a reasonable fee to the Independent Review Organization to

conduct the review, but such fee is not contingent upon the determination of the Independent Review Organization or Independent Medical Reviewer.

- c. **An Independent Medical Reviewer** is a physician that is licensed in one or more States to deliver health care services and typically treats the condition or illness that is the subject of the claim under review. The Independent Medical Reviewer is not an employee of the Company and does not provide services exclusively for the Company or for individuals holding insurance coverage with the Company. The Independent Medical Reviewer has no material financial, familial or professional relationship with the Company, with an officer or director of the Company, with the claimant or the claimant's Authorized Representative, with the health care professional that provided the intervention involved in the denied claim; with the institution at which the intervention involved in the denied claim was provided; with the manufacturer of any drug or other device used in connection with the intervention involved in the denied claim; or with any other party having a substantial interest in the denied claim.

4. **Documentation**

- a. **Written Appeals.** You must submit your appeal in writing in a form and in a manner determined by the Arkansas Insurance Commissioner. You may submit with your request for review any additional written comments, issues, documents, records and other information relating to your claim. Your request for external review must be submitted on the forms provided by the Arkansas Insurance Department. You can obtain the forms by writing to the Arkansas Insurance Department, External Review, 1 Commerce Way, Suite 102, Little Rock, Arkansas 72202 or by calling (800) 852-5494. The forms are also available online at the Arkansas Insurance Department website at insurance.arkansas.gov.
- b. **Authorization to Release Information.** In filing your request for external review, you must include the following authorization: "I, [Covered Person's name], authorize Arkansas Blue Cross and Blue Shield and my healthcare Provider(s) to release all medical information or records pertinent to this claim to the Independent Review Organization that is designated by Arkansas Blue Cross. I further authorize such Independent Review Organization to release such medical information to any Independent Medical Reviewer(s) selected by the Independent Review Organization to conduct the review."

5. **Referral of Review Request to an Independent Review Organization.** Upon receipt of the documentation set out in Subsection 7.3.4, the Arkansas Insurance Commissioner shall immediately refer the request for external review, along with the Company's initial determination of the claim and the Appeals Coordinator's internal review determination (if applicable) to an Independent Review Organization.

6. **Independent Review Organization Right to Information.** You and your treating health care professional are required to provide the Independent Review Organization and the Independent Medical Reviewer(s), upon request, access to information necessary to determine the appeal. Access to such information shall be provided not later than seven (7) business days after the date on which the request for information is received.

7. **Rejection of Request for Review by the Independent Review Organization.** The Independent Review Organization shall reject a request for review and notify you, your Authorized Representative and the Appeals Coordinator in writing within five (5) business days (or within 72 hours for an Expedited Appeal) of its determination, if it determines that the appeal does meet the standards for an appeal for external review. See Subsections 7.3.1.

8. **Rejection of the Review for Failure to Submit Requested Information.** The Independent Review Organization may reject a request for review if:

- a. you have not provided the authorization for release of medical records or information pertinent to the claim required by Subsection 7.3.4.b; or
- b. you or your health care professional have not provided information requested by the Independent Review Organization in accordance with Subsection 7.3.6.

9. **Independent Medical Review Determination.** If the Independent Review Organization does not reject the request for review in accordance with Subsections 7.3.7 or 7.3.8, it shall assign the request for review to an Independent Medical Reviewer. Such Independent Medical Reviewer shall make a determination after reviewing the documentation submitted by you, your health care professional and the Company. The Independent Medical Reviewer shall consider the terms of this Benefit Certificate to assure that the reviewer's decision is not contrary to the terms of the Plan. In making the determination the reviewer need not give deference to the determinations made by the Company or the recommendations of the treating health care professional (if any).
10. **Timing of Appeal Determination.**
 - a. **Standard Review.** The Independent Medical Reviewer shall complete a review on an appeal within a reasonable period of time, but in no case later than forty five (45) days after the Independent Review Organization received the appeal.
 - b. **Expedited Review.** If you request an expedited review, and a health care professional certifies that the time for a standard review would seriously jeopardize your life or health or your ability to regain maximum function, the Independent Medical Reviewer shall make a determination on review in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Independent Review Organization received the request for review.
11. **Notification of Determination of Independent Medical Review.**
 - a. **Recipients of Notice.** Upon receipt of the determination of the Independent Medical Reviewer, the Independent Review Organization shall provide written notification of the determination to you, your health care Provider, the Company and the Arkansas Insurance Commissioner.
 - b. **The Notification shall include.**
 - i. A general description of the reason for the request for external review;
 - ii. The date the Independent Review Organization was notified by the Company to conduct the review;
 - iii. The date the external review was conducted;
 - iv. The date of the Independent Medical Reviewer's determination;
 - v. The principal reason(s) for the determination;
 - vi. The rationale for the determination; and
 - vii. References to the evidence or documentation, including practice guidelines, considered in the determination.
12. **Expedited External Review.**
 - a. **Requirement for Expedited Review.** You may submit a pre-service claim denial or a denial of a claim involving concurrent care for an expedited external review provided your health care professional certifies that the time to complete a standard review would seriously jeopardize your life or health or your ability to regain maximum function.
 - b. **Expedited External Review without prior Appeal to Plan (internal review).** You may request an expedited review at the same time you submit a request for an appeal to the Plan (internal review) if your health care professional certifies that the time to complete the Plan's expedited appeal process would seriously jeopardize your life or health or your ability to regain maximum function. If you make such a request, the Independent Review Organization may determine and notify you in accordance with Subsections 7.3.10.b. and 7.3.11 whether you will be required to complete the internal review process.

- c. **Same procedures as standard external review.** Unless otherwise specified, the provisions of this Section 7.3 applicable to independent medical review of claims apply to expedited external review of claims.
- 13. **Other Rights under Plan.** Your decision to submit an appeal to external review will have no effect on your other rights and benefits under the Plan.
- 14. **Arkansas Insurance Commissioner.** You may contact the Arkansas Insurance Commissioner for assistance. The mailing address is Arkansas Insurance Department, Attention External Review Assistance, 1 Commerce Way, Suite 102, Little Rock, AR 72202. The telephone number is (501) 371-2640 or toll free (800) 852-5494. The e-mail address is insurance.consumers@arkansas.gov.
- 15. **Binding on the Plan.** The determination of an Independent Review Organization and an Independent Medical Reviewer is binding on both the Plan and you, except to the extent that other remedies are available under applicable federal or state law.

7.4 Authorized Representative

- 1. **One Authorized Representative.** A Covered Person may have one representative, and only one representative at a time, to assist in submitting a claim or appealing an unfavorable claim determination.
- 2. **Authority of Authorized Representative.** An Authorized Representative shall have the authority to represent the Covered Person in all matters concerning the Covered Person's claim or appeal of a claim determination. If the Covered Person has an Authorized Representative, references to "You" or "Covered Person" in this document refer to the Authorized Representative.
- 3. **Designation of Authorized Representative.** One of the following persons may act as a Covered Person's Authorized Representative:
 - a. An individual designated by the Covered Person in writing in a form approved by the Company;
 - b. The treating Provider, if the claim is a claim involving urgent care, or if the Covered Person has designated the Provider in writing in a form approved by the Company;
 - c. A person holding the Covered Person's durable power of attorney;
 - d. If the Covered Person is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Covered Person by a court of competent jurisdiction; or
 - e. If the Covered Person is a minor, the Covered Person's parent or legal guardian, unless the Company is notified that the Covered Person's claim involves health care services where the consent of the Covered Person's parent or legal guardian is or was not required by law and the Covered Person shall represent himself or herself with respect to the claim.
- 4. **Communication with Authorized Representative.**
 - a. If the Authorized Representative represents the Covered Person because the Authorized Representative is the Covered Person's parent or legal guardian or attorney in fact under a durable power of attorney, the Company shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.
 - b. If the Authorized Representative represents the Covered Person in connection with the submission of a pre-service claim, including a claim involving urgent care, or in connection with an appeal, the Company shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.
 - c. If the Authorized Representative represents the Covered Person in connection with the submission of a post-service claim, the Company will send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Covered Person,

but the Company will provide copies of such correspondence to the Authorized Representative upon request.

5. **Term of the Authorized Representative.** The authority of an Authorized Representative shall continue until
 - a. the claim(s) or appeal(s) for which the Authorized Representative was designated has been fully adjudicated; or
 - b. the Covered Person is legally competent to represent himself or herself and notifies the Company that the Authorized Representative is no longer required.

8.0 OTHER PROVISIONS

The following information is important in the administration of the Plan.

- 8.1 **Assignment of Benefits.** No assignment of benefits under this Benefit Certificate shall be valid until approved and accepted by the Company. The Company reserves the right to make payment of benefits, with a valid assignment, directly to the Provider of service.
- 8.2 **Right of Rescission.** The performance of an act or practice constituting fraud or intentional misrepresentation of material fact may be used by the Company as the basis for rescission of coverage of the Policyholder, any Employee or any Dependents. The Company must provide the Policyholder 30 days' advance written notice of its intent to rescind the Benefit Certificate.
- 8.3 **Claim Recoveries.** There may be circumstances in which the Company recovers amounts paid as claims expense from a Provider of services, from a Covered Person or from a third party. Such circumstances include rebates paid to the Company by pharmaceutical manufacturers based upon amounts of claims paid by the Company for certain specified pharmaceuticals, amounts recovered by the Company from health care Providers or pharmaceutical manufacturers through certain legal actions instituted by the Company relating to the claims expense of more than one Covered Person, recoveries by the Company of overpayments made to health care Providers or to Covered Persons, and recoveries from other parties with whom the Company contracts or otherwise relies upon for payment or pricing of claims. The following rules govern the Company's actions with respect to such recoveries:
 1. In the event that such a recovery relates to a claim paid more than two years before the recovery, no adjustment will be made to any Deductible or Coinsurance paid by a Covered Person and the Company shall be entitled to retain such recoveries for its own use.

If the recovery relates to a claim paid within two years and is not otherwise addressed in this subsection, Deductibles and Coinsurance amounts for a Covered Person will be adjusted if affected by the recovery.
 2. Only recoveries made within two years of the date of the error by the Company or overpayments to health care Providers or to Covered Persons by the Company will be applied for the purpose of group rating or divisible surplus calculation, if applicable. The cost actually paid by the Company to procure such recoveries will be treated as an administrative expense in considering group rating or divisible surplus, if applicable.
 3. In the event the Company receives or will receive from pharmaceutical manufacturers rebates based upon amounts of claims paid for certain specified pharmaceuticals, the Company shall make adjustments to claims paid for Deductible or Coinsurance or to Deductibles or Coinsurance amounts paid by a Covered Person at the point of sale, provided the adjustment reduces the Covered Person's Deductible or Coinsurance.
 4. If a Covered Person is no longer covered by the Company at the time of any such recovery, regardless of the amount or of the time of such recovery, the Company shall be entitled to retain such recovery for its own use.
 4. If such recovery amounts cannot be attributed on an individual basis, because of having been paid as a lump sum settlement for less than the total amount of claims expense of the Company or

otherwise, no adjustments will be made to any Deductible or Coinsurance amounts paid by the Covered Person and the Company shall be entitled to retain such recovery for its own use.

8.4 **Amendment** The Company reserves the right to change the benefits, conditions and premiums covered under the Group Policy or Group Insurance Contract, including the terms of this Benefit Certificate. In the event of a change to the Group Policy or Group Insurance Contract, We will give thirty (30) days written notice to your Employer or its agent prior to the group's next renewal, and the change will go into effect on the date fixed in the notice. No agent or employee of the Company may change or modify any benefit, term, condition, limitation or exclusion of this Benefit Certificate. Any change or amendment must be in writing and signed by an officer of the Company and approved by Arkansas Insurance Department.

8.5 **Notice of Provider/Physician Incentives That Could Affect Your Access to Healthcare**

1. **General Description and Purpose of Incentive Programs:** The Company contracts with physicians and other types of health care providers who agree to perform services for Arkansas Blue Cross and Blue Shield Covered Persons, often at a discount from their usual charges. In contracting with providers, including physicians, the Company sometimes offers financial incentives to encourage providers to practice medicine in a cost-effective manner, and to improve the quality of health care services. These incentive arrangements sometimes offered by the Company may take a variety of forms but the main goals of the incentive arrangements are designed to do one or both of two things: (1) give the provider (including physicians) a financial incentive to control the overall cost of treatment; and (2) give the provider (including physicians) a financial incentive to pay increased attention to well-established quality standards and thereby hopefully improve the overall quality of care being provided. The financial incentives sometimes offered by the Company to providers (including physicians) sometimes involve a financial reward if specified goals are met; at other times, the financial incentives may include a financial penalty if the provider (including physicians) fails to achieve specified goals. In other cases, the financial incentive program that the Company offers to providers (including physicians) may include both the opportunity for financial rewards, as well as the possibility of financial penalties, depending on how the provider performs.
2. **Specific Types of Incentive Programs Offered:** The financial incentives offered by the Company to providers (including physicians) may change significantly over time and on short notice due to provider preferences or larger changes taking place in the health care field; however, the following describes a number of financial incentive programs that are either currently being offered by the Company, or may be offered in the future:
 - a. **Capitation:** This is a system of provider (including physician) payment in which the Company agrees to pay the provider a per-member-per-month fee as total compensation for all of the care received by each Covered Person from the contracting provider during the month. Sometimes, capitation involves a "withhold" feature in which a portion of the capitation payment is withheld until the provider's overall cost performance is determined at the end of a defined settlement period. In such instances, if the provider's overall cost of care for Covered Persons is lower than a pre-determined target budget, the provider is then paid an additional amount from the withhold fund; conversely, in some instances, if the provider's overall cost of care for Covered Persons is higher than a pre-determined target budget, the provider may forfeit some or all of the withhold fund.
 - b. **Episodes of Care:** This is a system of provider (including physician) payment in which the Company and the provider agree on a pre-determined set of cost and quality measurements that will apply to a specific type of health care episode, such as, for example, total hip or knee replacement surgery. In this "episodes of care" incentive payment system, a provider may qualify for incentive bonus payments by accomplishing two things: first, the provider must establish that certain quality standards have been met with respect to Covered Persons treated by the provider within the applicable review period and, secondly, the provider must keep average costs for the particular "episode of care" in question within pre-established ranges. At the same time, if the provider's average costs for Covered Persons treated in a particular "episode of care" exceed an "acceptable" range that is pre-established in the agreement with the Company, the provider will not earn bonus payments and may also be required to refund a portion of the claims payments the provider previously received from the

Company. Please keep in mind that the Company currently applies this form of provider payment to only a small number of health care treatments or “episodes” but may expand the list to cover additional “episodes of care” over time. Please note as well that a provider’s referral of Covered Persons to other providers, including specialists, could affect the provider’s qualification for bonus payments, or the provider’s obligation to refund some payments made by the Company. For example, if a provider makes referrals to other providers whose costs of care are substantially higher, or who do not meet applicable quality standards, the referring provider could lose bonus payments, or could incur refund obligations to the Company under the “episodes of care” payment system.

- c. Total Cost of Care or Medical Trends: In some instances, the Company may offer financial incentives to providers (including physicians) that are tied to the total cost of care for a pre-defined set of Covered Persons within a pre-defined period of time, offering to pay such providers a bonus payment if, during the defined period, total costs of care for such Covered Persons remains at or below a pre-defined target level. Sometimes this form of payment is based on calculations of the “medical trend” during a defined period, which means whether the cost of care for Covered Persons served by the provider during the applicable period increased or decreased by a specific percentage.
- d. Pharmacy/Drug Incentives: The Company may also offer physicians financial incentives to encourage them to provide education to Covered Persons on the costs of Prescription Medications, and, where appropriate in the physician’s independent medical judgment, to write prescriptions for Prescription Medications listed as “Second Tier” on the Company’s Formulary, or to write prescriptions for Generic Medications listed as “First Tier” on the Company’s Formulary.

3. **Incentive Arrangements Subject to Change.** The incentive arrangements described here concern the provider contracts that are either in place and regularly used by the Company at the time this Benefit Certificate was issued or are being contemplated for use in the future. Because of the rapid pace of change in health care financing in today’s marketplace, physician provider negotiating positions, regulatory changes, or other developments, the precise content of the Company’s provider reimbursement and incentive plans may change significantly in the future. See subsection 4, below, for ways in which you can obtain additional or updated information regarding the Company’s provider incentive programs.

4. **For Further Information.** If you have any concerns about how the various incentive programs offered to the Company’s-participating providers may affect your access to health care services, you should discuss such concerns with your physician or other treating health care professional. You may ask your Physician’s health care provider’s administrative staff about compensation methods, including incentives, which apply to the services provided by their Physician, your health care provider. In addition, you may or request information from the Company by writing to submit written questions to Arkansas Blue Cross and Blue Shield, Customer Service Division, Post Office Box 2181 Little Rock, Arkansas 72203.

8.6 **Pediatric Dental Plan.** Your Plan is bundled with pediatric dental coverage. A Pediatric Dental plan provides coverage for dental services to Covered Persons under the age of nineteen (19) subject to the terms, conditions, exclusions, and limitations of the Pediatric Dental Benefit Certificate. While coverage is provided under this Plan, the Company will not send the Pediatric Dental Benefit Certificate and materials to any family (i.e., Employees or their Dependents) without a Covered Person under the age of nineteen (19). If your coverage is amended to include a Covered Person under the age of nineteen (19), you will receive a Pediatric Dental Benefit Certificate and materials at the address currently on file with the Company.

8.7 **Value Adds.** We may offer You access to non-insurance benefits and services such as subscriptions to wellness and/or meditation apps, merchandise, special offers, coupons, or other items of value through a non-insurance program vendor. These non-insurance services may be managed by the non-insurance program vendor’s administrator named as the program administrator. The products and services available under these programs may provide duplicative benefits to Covered Services in this Benefit Certificate or to another non-insurance program vendor but are not Covered Services under the Policy. As such, program features are not guaranteed under the Policy and could be discontinued at any time. Neither We nor the

program administrator endorses any vendor, product or service associated with any non-insurance benefit or services program. Non-insurance program vendors are solely responsible for the non-insurance products and services You may receive

9.0 GLOSSARY OF TERMS

These are terms used in this Group Policy and Benefit Certificate.

- 9.1 **Accidental Injury** is defined as bodily injury sustained by a Covered Person while the insurance is in force, and which is the direct cause of the loss, independent of disease or bodily infirmity. Injury to a tooth or teeth while eating is not considered an Accidental Injury.
- 9.2 **Allowance or Allowable Charge**, when used in connection with Covered Services or supplies delivered in Arkansas, will be the amount deemed by the Company, in its sole discretion, to be reasonable. The Arkansas Blue Cross and Blue Shield customary allowance is the basic Allowance or Allowable Charge. However, the Allowance or Allowable Charge may vary, given the facts of the case and the opinion of the Company's medical director.

At the option of the Company, Allowances or Allowable Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See Subsection 7.1.10 dealing with Out-of-Arkansas Services. See Subsection 3.25.4 with respect to the Allowance or Allowable Charge for transplants. See Subsection 3.3.2 with respect to the Allowance or Allowable Charge for Outpatient Surgery Centers. **Please note that all benefits under this Benefit Certificate are subject to and shall be paid only by reference to the Allowance or Allowable Charge as determined at the discretion of Arkansas Blue Cross and Blue Shield. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Benefit Certificate will be limited by the Allowance or Allowable Charge we establish. If you use an Arkansas Blue Cross and Blue Shield-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of the Arkansas Blue Cross and Blue Shield Allowance or Allowable Charge.**

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowance or Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Benefit Certificate with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Benefit Certificate, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Benefit Certificate are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also

furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Benefit Certificate for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Benefit Certificate is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Benefit Certificate shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Benefit Certificate will pay only one Allowance or Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowance or Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Preferred Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Benefit Certificate are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Benefit Certificate will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

- 9.3 **Alternative Destination** means a lower-acuity facility that provides medical services, including without limitation: a.) a federally qualified health center; b.) an urgent care center; c.) a physician office or medical clinic selected by the patient; and d.) a behavioral or mental healthcare facility including without limitation a Crisis Stabilization Unit. Alternative Destination does not include: a.) a critical access Hospital; b.) a dialysis center; c.) a Hospital; d.) a private residence; or e.) a Skilled Nursing Facility.
- 9.4 **Ambulance Service** means surface or air transportation in a regularly equipped ambulance licensed by an appropriate agency and where the use of any other means of transportation is not medically indicated. All services provided by the ambulance personnel, including but not limited to, the administration of oxygen, medications, life support, etc. are included in the specific Benefit Certificate limitation applied to ambulance benefits per calendar year.
- 9.5 **Ambulatory Surgery Center** means a distinct entity that operates exclusively for the purpose of providing

surgical services to patients not requiring Hospitalization.

- 9.6 **Ancillary Services** means services provided by Out-of-Network Providers at an In-Network facility such as: related to emergency medicine – anesthesiology, pathology, radiology and neonatology; provided by assistant surgeons, hospitalists and intensivists; diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of ancillary services as determined by the Secretary (as that term is applied in the No Surprises Act); provided by such other specialty practitioners as determined by the Secretary; and provided by an Out-of-Network Physician when no other In-Network Physician is available.
- 9.7 **Annual Limitation on Cost Sharing** means the amount of Allowance or Allowable Charges a Covered Person must incur for claims in a calendar year before the Covered Person is relieved of the obligation to pay Copayments, Deductible or Coinsurance for the remainder of the calendar year. The Annual Limitation on Cost Sharing is set forth in the Schedule of Benefits.
- 9.8 **Approved Clinical Trial** means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or condition and is described in any of the following subparagraphs:
1. Federally Funded Trials- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. cooperative group or center of any of the entities described in clauses a. through b. or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
 3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- 9.9 **Benefit Certificate** means this certificate of insurance containing the benefits, conditions, limitations and exclusions of the Group Insurance Contract plus the Schedule of Benefits and any amendments signed by an Officer of the Company.
- 9.10 **Biosimilar Medication** means a biological product that is highly similar to a biological product already approved by the FDA (i.e. reference product) and is licensed and approved by the FDA.
- 9.11 **Brand Name Medication** means any Prescription Medication that has a patented trade name separate from its generic or chemical designation.
- 9.12 **Case Management** is a program in which a registered nurse employed by Arkansas Blue Cross and Blue Shield, known as a Case Manager, assists a Covered Person through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and health care benefits available to a Covered Person. Case management is instituted at the sole option of the Company when mutually agreed to by the Covered Person and the Covered Person's Physician.
- 9.13 **Chemotherapy** means Chemotherapy for the treatment of a malignant neoplastic disease by chemical agents that affect the disease-causing agent unfavorably. High dose Chemotherapy is Chemotherapy several times higher than the standard dose for malignant disease (as determined in recognized medical compendia) and which would automatically require the addition of drugs and procedures (e.g., Granulocyte Colony-Stimulating Factor, Granulocyte-Macrophage Colony-Stimulating Factor, re-infusion of stem cells, re-infusion of autologous bone marrow transplantation, or allogeneic bone marrow transplantation) in any patient

who received this high dose Chemotherapy, to prevent life-threatening complications of the Chemotherapy on the patient's own progenitor blood cells.

- 9.14 **Child** means an Employee's natural Child, legally adopted Child or Stepchild. "Child" also means a Child that has been placed with the Employee for adoption. "Child" also means a Child for whom the Employee must provide medical support under a qualified medical child support order or for whom the Employee has been appointed the legal guardian.
- 9.15 **Cognitive Rehabilitation** means a treatment modality designed specifically for the remediation of disorders of perception, memory and language in traumatic brain-injured persons. Services or supplies provided as or in conjunction with, Cognitive Rehabilitation are not covered. See Subsection 4.2.15.
- 9.16 **Coinsurance** means the obligation of a Covered Person to pay a certain portion of an Allowable Charge. Coinsurance is expressed as a percentage in the Schedule of Benefits. The Schedule of Benefits sets forth the Coinsurance for services or supplies received from a Preferred Provider and the Coinsurance for services and supplies from Non-Preferred Provider.
- 9.17 **Company** means Arkansas Blue Cross and Blue Shield.
- 9.18 **Compound Medication** means a non-FDA approved medication prescribed by a Physician that is mixed by a pharmacist using multiple ingredients which may or may not be FDA approved individually. FDA approved medications that exist as separate components and are intended for reconstitution prior to administration are not Compound Medications.
- 9.19 **Contracting Provider** means a Provider who has signed a Contract with this Company to provide the services covered by this Benefit Certificate to Covered Persons. The Company will pay the Contracting Provider directly.
- 9.20 **Copayment** means the amount required to be paid to a Preferred Provider by or on behalf of a Covered Person in connection with Covered Services.
- 9.21 **Cosmetic Service** means any treatment or corrective surgical procedure performed to reshape structures of the body in order to alter the individual's appearance or to alter the manifestation of the aging process. Breast augmentation, mastopexy, breast reduction for cosmetic reasons, otoplasty, rhinoplasty, collagen injection and scar reversals are examples of Cosmetic Services. Cosmetic Services also includes any procedure required to correct complications caused by or arising from prior Cosmetic Services. Cosmetic Services do not include the following services in connection with a mastectomy eligible for coverage under this Benefit Certificate: (a) reconstruction of the breast on which the surgery has been performed, and (b) surgery to reconstruct the other breast to produce a symmetrical appearance. The following procedures are not considered Cosmetic Services: correction of a cleft palate or cleft lip, removal of a port-wine stain or hemangioma on the head, neck, or face.
- 9.22 **Coverage Policy** means a statement developed by the Company that sets forth the medical criteria for coverage under an Arkansas Blue Cross and Blue Shield Benefit Certificate or insurance policy. Some limitations of benefits related to coverage, of a drug, treatment, service equipment or supply are also outlined in the Coverage Policy. A copy of a Coverage Policy is available from the Company, at no cost, upon request, or a Coverage Policy can be reviewed on the Company's web site at WWW.ARKANSASBLUECROSS.COM.
- 9.23 **Covered Person** means an Employee or Dependent who is insured under this Benefit Certificate.
- 9.24 **Covered Services** means services for which a Covered Person is entitled to benefits under the terms of this Group Policy and Benefit Certificate.
- 9.25 **Crisis Stabilization Unit** means a public or private facility, licensed and certified as a Crisis Stabilization Unit by the Arkansas Department of Human Services, that serves as an alternative to jail, where law enforcement officers can place people experiencing mental health crises who have been arrested for nonviolent offenses
- 9.26 **Custodial Care** means care rendered to a Covered Person (1) who is disabled mentally or physically and such disability is expected to continue and be prolonged, and (2) who requires a protected, monitored, or controlled environment whether in an institution or in a home, and (3) who requires assistance to support the essentials of daily living, and (4) who is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the

protected, monitored, or controlled environment. A custodial determination is not precluded by the fact that a Covered Person is under the care of a supervising or attending Physician and that services are being ordered or prescribed to support and generally maintain the Covered Person's condition, or provide for the Covered Person's comfort, or ensure the manageability of the Covered Person. Further, a Custodial Care determination is not precluded because the ordered and prescribed services and supplies are being provided by an R.N., L.P.N., or L.V.N. or the ordered and prescribed services and supplies are being performed in a Hospital, Nursing Home, a skilled nursing facility, an extended care facility or in the home. The determination of Custodial Care in no way implies that the care being rendered is not required by the Covered Person; it only means that it is a type of care that is not covered under this Benefit Certificate.

- 9.27 **Deductible** means the amount of out-of-pocket expense a Covered Person must incur for Covered Services each calendar year before any expenses are paid by the Company under the Plan. This amount is calculated from the Allowance or Allowable Charges, not the billed charges. Once the Deductible has been met, subject to all other terms, conditions, limitations and exclusions in the Plan, Coinsurance payments for Covered Services begin.
- 9.28 **Dental Care** means the treatment or repair of the teeth, bones and tissues of the mouth and defects of the human jaws and associated structures and shall include surgical procedures involving the mandible and maxilla where such is done for the purpose of correcting malocclusion of the teeth or for the purpose, at least in part, of preparing such bony structure for dentures or the attachment of teeth, artificial or natural. Dental Care shall include any related supplies or oral appliances used in the treatment, diagnosis or prevention of any defects in the teeth or supporting tissues of the mouth. Expenses for such treatment or repair are considered Dental Care regardless of the reason for the services. Generally, hospital services and administration of anesthetic in connection with Dental Care are not covered except in limited circumstances, as provided in Subsection 3.3.3.
- 9.29 **Dependent** means any member of an Employee's family who meets the eligibility requirements of Section 6.0, who is enrolled in the Plan, and for whom the Company has received premium.
- 9.30 **Developmental Service Visit** means one hour of Developmental Services provided by a licensed or certified provider. A Developmental Service Visit may include services provided by more than one provider.
- 9.31 **Developmental Services** means assistance activities that are coordinated with physical, occupational and speech therapy to reinforce impact of such therapy provided in connection with Habilitation.
- 9.32 **Diabetes Self-Management Training** means instruction, including medical nutrition therapy relating to diet, caloric intake and diabetes management (excluding programs the primary purpose of which is weight reduction) which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent Hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.
- 9.33 **Dose Limitation** means a limitation in the number of doses of a Prescription Medication in a single prescription or a limit in the number of doses over a defined period of time. For example, a Dose Limitation for a particular medication may be set at no more than 10 doses in a dispensed prescription and no more than 20 doses during a 30-day period.
- 9.34 **Durable Medical Equipment (DME)** means equipment which (1) can withstand repeated use; and (2) is primarily and customarily used to serve a medical purpose; and (3) generally is not useful to a person in the absence of an illness or injury; and (4) is appropriate for use in the home.
- 9.35 **Electronic Data Exchange Enrollment** means the process by which a Policyholder submits eligibility data electronically to the Company for the purposes of adding, deleting or modifying the Company's enrollment records. Electronic data submitted to the Company will be relied upon in determining eligibility, effective dates and termination dates of coverage under the terms of the employee health benefit plan.
- 9.36 **Eligibility Data** means information demonstrating that an Employee or Employee's Dependent is eligible for coverage under the Plan.
- 9.37 **Eligibility Date** means:
- For an Employee, the latest of the following dates:

1. the Benefit Certificate effective date for an Employee who has selected coverage and is working for the Employer on that date; or
2. the date the required Waiting Period is completed for any Employee hired after the Benefit Certificate effective date.

For a Dependent, the latest of the following dates:

1. the date the Employee becomes eligible for coverage under the Plan;
2. the date a person becomes a Dependent; or
3. the date this Benefit Certificate is amended to include the Employee's class as being eligible for Dependent coverage.

9.38 **Emergency Care** means health care services required to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that a condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in (i) placing the patient's health in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. Emergency health care services, with respect to emergency medical condition, means a medical screening examination within the capability of an emergency department of a hospital or an independent freestanding emergency department including ancillary services routinely available to evaluate the emergency medical condition. This includes emergency services to stabilize the patient within any department of the hospital in which further examination or treatment is provided. Emergency services will include items and services provided by an Out-of-Network provider or facility within any department of the hospital where such items or services are provided after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to stabilizing the patient. In order to qualify as Emergency Care, health care services must be sought within forty-eight (48) hours of the onset of the illness or Accidental Injury. In order to qualify as Emergency Care, health care services must be sought in a facility licensed by the state to provide emergency services within forty-eight (48) hours of the onset of the illness or Accidental Injury.

9.39 **Emergency Prescription** means any Prescription Medication prescribed in conjunction with Emergency Care and deemed necessary by a Physician to be immediately needed by the Covered Person.

9.40 **Employee** means a person who is directly employed by the Employer for Full-Time Employment. This person must reside in the United States and be paid for full-time work in the conduct of the Employer's regular business. No director or officer of the Employer shall be considered an Employee unless he meets the above conditions.

9.41 **Employer** means a sole proprietorship, partnership, or corporation which is the Policyholder. Employer, Group, Member and Policyholder shall have a common meaning when used herein.

9.42 **Exchange** means a governmental agency or non-profit entity, which meets the applicable standards of the federal Affordable Care Act of 2010 and implementing rules, that makes Qualified Health Plans available to Qualified Individuals.

9.43 **Facility** means any provider providing medical services to beneficiaries

9.44 **Formulary** means a specified list of Prescription Medications covered by the Company. The services of an independent National Pharmacy and Therapeutics Committee (P&T Committee) are utilized to approve safe and clinically effective drug therapies on the Formulary. The P&T Committee is an external advisory body of experts from across the United States. The P&T Committee's voting members include physicians, pharmacists, a pharmacoeconomist and a medical ethicist, all of whom have a broad background of clinical and academic expertise regarding prescription drugs.

Prescription Medications on the Formulary are classified into various cost tier designs based on the benefit. Prescription Medication tiers are classified as Preventive Medications, Generic Medications, Brand Name Medications, and Specialty Medications. The list of Prescription Medications that make up the Formulary and the tier classification of a Prescription Medication on the Formulary are subject to change by the Company and the Pharmacy and Therapeutics Committee. In recommending whether to place a Prescription Medication on the Formulary or to place a Prescription Medication in a tier classification in the Formulary, the

Pharmacy and Therapeutics Committee compares a Prescription Medication's safety, effectiveness, cost efficiency and uniqueness with other Prescription Medications in the same category. **Prescription Medications including new Prescription Medications approved by the FDA are not covered under this Benefit Certificate unless or until the Company places the medication on the Formulary.**

- 9.45 **Freestanding Facility** means an entity that furnishes health care services and that is neither integrated with, nor a department of, a Hospital. Physically separate facilities on the campus of a Hospital are considered freestanding unless they are integrated with, or a department of, the Hospital. Examples of Freestanding Facilities include, but are not limited to, Free-Standing Cardiac Care Facilities and Free-Standing Residential Treatment Centers. Ambulatory Surgery Centers performing Covered Services provided in 3.4 are not considered Freestanding Facilities. Laboratories are not considered Freestanding Facilities.
- 9.46 **Full-Time Employment**, full-time active Employee, and like terms, mean a job with the Employer:
1. on a permanent and active basis;
 2. for compensation; and
 3. for at least thirty (30) hours a week, forty-eight (48) weeks per year.
- 9.47 **Generic Medication** means any US Food and Drug Administration ("FDA") approved, chemically identical, reproduction of a Brand Name Medication for which the patent has expired. A Prescription Medication must have a price at least twenty percent (20%) lower than the Brand Name Medication in order to qualify as a Generic Medication for reimbursement purposes.
- 9.48 **Group Policy or Group Insurance Contract** means the insurance policy issued by the Company to the Employer.
- 9.49 **Habilitation** means health care services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition.
- 9.50 **Health Intervention or Intervention** means an item, Medication or service delivered or undertaken primarily to diagnose, detect, treat, palliate or alleviate a medical condition or to maintain or restore functional ability of the mind or body.
- 9.51 **Hearing Aid** means an instrument or device, including repair and replacement parts, that
1. is designed and offered for the purpose of aiding persons with or compensating for impaired hearing;
 2. is worn in or on the body; and
 3. is generally not useful to a person in the absence of a hearing impairment.
- 9.52 **Homeopathic** means healing the underlying cause of disease not simply eliminating the symptoms caused by the disease. Some forms of homeopathic treatment may include, but are not limited to diet therapy, environment services, minimum doses of natural medications. Homeopathic treatments are not covered. See Subsection 4.2.65.
- 9.53 **Hospice Care** means an autonomous, centrally administered, medically directed, coordinated program providing a continuum of home, outpatient and home-like inpatient care for the terminally ill patient and family. Hospice Care provides palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement.
- 9.54 **Hospital** means an acute general care Hospital and a Rehabilitation Hospital licensed as such by the appropriate state agency. It does not include any of the following, unless required by applicable law or approved by the Board of Directors of the Company: Hospitals owned or operated by state or federal agencies, convalescent homes or Hospitals, homes for the aged, sanitariums, long term care facilities, infirmaries, or any institution operated mainly for treatment of long-term chronic diseases.
- 9.55 **In-Network Provider** means a Preferred Provider or a Contracting Provider who has signed a contract with the Company to provide the Covered Services by this Benefit Certificate to Covered Persons. The Company pays an In-Network Provider directly.
- 9.56 **Laboratory** means an entity furnishing biological, microbiological, serological, chemical,

immunohematological, hematological, biophysical, cytological, pathological or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure or otherwise describe the presence or absence of various substances or organisms in the body. Entities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered laboratories.

- 9.57 **Late Enrollee** means a Covered Person who submits an application for coverage other than during:
1. the first period in which the Covered Person is eligible to enroll in the Plan; or
 2. a Special Enrollment Period.
- 9.58 **Life-Threatening Disease or Condition** means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted
- 9.59 **Long-Term Acute Care** means the medical and nursing care treatment of medically stable but fragile patients over an extended period of time, anticipated to be at least 25 days. Long Term Acute Care includes, but is not limited to, treatment of chronic cardiac disorders, ventilator dependent respiratory disorder, post-operative complications and total parenteral nutrition (TPN) issues.
- 9.60 **Low Protein Modified Food Products** means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of a Medical Disorder Requiring Specialized Nutrients or Formulas.
- 9.61 **Maintenance Medication** means a specific Prescription Medication: (1) for ongoing therapy of a chronic illness; and (2) that has been designated as a Maintenance Medication by the Company. You may obtain a list of Maintenance Medications by calling Customer Service.
- 9.62 **Maternity Care and Obstetrical Care** means Health Interventions necessary because of or related to the following conditions: premature rupture of membranes; false labor; occasional spotting in pregnancy; pre-term labor; pre-term birth; physician prescribed rest during the pregnancy; morning sickness; hyperemesis gravidarum; cephalopelvic disproportion; intrauterine growth retardation; analysis for fetal down syndrome, analysis for hepatitis C, trisomy 18 or neural tube defect; congenital diaphragmatic hernia; hydrops fetalis; group B strep prophylaxis in pregnancy; isoimmunization in pregnancy; antepartum fetal surveillance; management of hyperemesis; cervical incompetence; fetal urethral obstruction; twin or greater gestation with prior uterine atony; macrosomia; incompetent cervix; forceps deliver; fetal fibronectin; cytotec for induction of labor; sudden onset of polyhydramnios; prophylactic cesarean delivery of HIV positive mother; Klippel-Trenaunay Syndrome; caudal regression syndrome; Hospitalization to postpone delivery until the fetus is further developed; biophysical profiles; fetal monitoring; non-routine ultrasounds; vaginal delivery; antepartum and postpartum care; or services related to c-sections scheduled because of (a) multiple gestation, (b) previous c-section delivery, (c) patient or physician convenience, (d) cephalopelvic disproportion or (e) abnormal presentations such as breech, shoulder dystonia, transverse and compound.
- 9.63 **Medical Disorder Requiring Specialized Nutrients or Formulas** means the following inherited metabolic disorders involving a failure to properly metabolize certain nutrients: nitrogen metabolism disorder; phenylketonuria; maple syrup urine disease; homocystinuria; citrullinemia; argininosuccinic academia; tyrosinemia, type 1; very-long-chain acyl-CoA dehydrogenase deficiency long-chain 3 hydroxyacyl-CoA dehydrogenase deficiency; trifunctional protein deficiency; glutaric academia, type 1; methylcrotonyl CoA carboxylase deficiency, propionic academia; methylmalonic academia due to mutase deficiency; methylmalonic academia due to cobalamin A,B defect; isovaleric academia; ornithine transcarbamylase deficiency; non-ketotic hyperglycinemia; glycogen storage diseases; disorders of creatine metabolism;

malonic aciduria; carnitine palmitoyl transferase deficiency type II; glutaric aciduria type II; and sulfite oxidase deficiency.

- 9.64 **Medical Food** means a food that is intended for dietary treatment of a Medical Disorder Requiring Specialized Nutrients or Formulas for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.
- 9.65 **Medical Literature** means articles from major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 42 U.S.C. §1395(x)(t)(2)(B), as amended.
- 9.66 **Medical Supply or Supplies** means an item which (1) is consumed or diminished with use so that it cannot withstand repeated use; and (2) is primarily or customarily used to serve a medical purpose; and (3) generally is not useful to a person in the absence of an illness or injury.
- 9.67 **Medicare** means either the two programs that comprise "Original Medicare" cited as the "Health Insurance for the Aged Act," Title I, Part I, of Public Law 89-97, as amended. Part A refers to Hospital insurance. Part B covers physician services and other clinical services or Medicare Advantage Part C, cited as the Medicare Modernization Act, Public Law 108-173.
- 9.68 **Mental Illness** means and includes (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions. This includes, but is not limited to schizophrenic spectrum and other psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma and stressor-related disorders, dissociative disorders, somatic symptom and related disorders, feeding and eating disorders, elimination disorders, sleep-wake disorders, sexual dysfunctions, gender dysphoria, disruptive, impulse-control and conduct disorders, substance-related and addictive disorders, neurocognitive disorders, personality disorders, paraphilic disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include only illnesses classified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C.)
- 9.69 **Minimum Essential Coverage** means coverage provided by any of the following:
1. A government sponsored plan such as Medicare, Medicaid, Department of Defense coverage for uniformed services, or the Department of Veterans Affairs;
 2. An employer sponsored health benefit plan;
 3. Comprehensive health coverage in the individual market;
 4. Other coverage, such as a State health benefits risk pool, recognized by the Secretary of Health and Human Services.
- 9.70 **Naturopathic** means a system of therapeutics in which neither surgical or medicine agents are used, dependence placed only on natural (non-medicinal) focus. Naturopathic treatments are not covered. See Subsection 4.2.64.
- 9.71 **Neurologic Rehabilitation Facility** means an institution licensed as such by the appropriate state agency. A Neurological Rehabilitation Facility must:
1. be operated pursuant to law;
 2. be accredited by the Joint Commission on Accreditation of Healthcare Organizations and the Commission on Accreditation of Rehabilitation Facilities;
 3. be primarily engaged in providing, in addition to room and board accommodations, rehabilitation services for Severe Traumatic Brain Injury under the supervision of a duly licensed Physician (M.D. or D.O.); and
 4. maintain a daily progress record for each patient.

- 9.72 **Non-Contracting Provider** means a Provider who has declined to sign a contract with this Company to provide to Covered Persons services covered by this Benefit Certificate. Non-Contracting Providers are free to bill and collect from you charges for Covered Services which are in excess of the Company's Allowance or Allowable Charge.
- 9.73 **Non-Diseased Tooth** means a 1.) virgin or unrestored tooth or 2.) a tooth that had no dental decay, no abscess, no periodontal disease or resorption associated with any bone loss, no dental implant, and previously functioned normally in chewing and speech.
- 9.74 **Non-Preferred Provider** means a Provider that does not participate in the Preferred Provider Organization.
- 9.75 **Open Enrollment Period** means the period annually, that is designated by the Employer and set forth in the Group Application, when Employees who are eligible for coverage may enroll in the Plan. During the Open Enrollment Period, Employees covered in the Plan may change their coverage, and that of their covered Dependents. Unless otherwise designated in this Benefit Certificate, enrollments and coverage changes made during the Open Enrollment Period become effective on the anniversary date of the Group Policy. If for any reason, Employer fails to designate an Open Enrollment Period, or the Group Application fails to indicate it, the Open Enrollment Period shall be the month prior to the anniversary of the effective date of the Group Policy.
- 9.76 **Orthotic Device** means a support, brace, or splint used to support, align, prevent, or correct the function of movable parts of the body.
- 9.77 **Out-of-Network Provider** means a Non-Contracting Provider who does not have a contract with the Company to provide Covered Services by this Benefit Certificate to Covered Persons. Out-of-Network Providers are free to bill and collect from you charges for Covered Services which are in excess of the Company's Allowance or Allowable Charge except in the limited situations outlined in Subsection 5.1.7.b, above.
- 9.78 **Outpatient Hospital** means a portion of a Hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under the supervision of, a Physician to patients treated on an outpatient basis for a variety of medical conditions and not kept overnight or otherwise admitted as inpatients to the Hospital.
- 9.79 **Outpatient Surgery Center or Radiation Therapy Center** means a facility licensed as such by the appropriate state agency.
- 9.80 **Outpatient Therapy Visit** means one unit of therapeutic service (usually one hour or less) provided by licensed Provider(s). An Outpatient Therapy Visit may include services provided by more than one Provider and in the case of physical therapy, up to four modalities of treatment. Any physical therapy or occupational therapy modality, regardless of who provides the service, is included in the visit limit. Outpatient therapy visit applies to therapy provided in a physician's office or in a physical therapy setting.
- 9.81 **Partial Hospitalization** means treatment for a Covered Person who is not at imminent risk of significant harm to self or others but requires a structured and monitored environment with access to the full spectrum of Health Interventions. Physicians normally prescribe services for at least 4 hours, but not more than 8 hours in any 24-hour period.
- 9.82 **Participating Pharmacy** means a licensed pharmacy that has contracted directly or indirectly with the Company to provide pharmacy services to Covered Persons subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate.
- 9.83 **Pharmaceutical Care** means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications as it relates to treatment of autism spectrum disorder
- 9.84 **Physician** means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) duly licensed and qualified to practice medicine and perform surgery at the time and place a claimed intervention is rendered. Physician also means a Doctor of Podiatry (D.P.M.), a Chiropractor (D.C.), a Psychologist (Ph.D.), a Dentist (D.D.S./D.M.D.) or an Optometrist (O.D.) duly licensed and qualified to perform the claimed Health Intervention at the time and place such intervention is rendered.

- 9.85 **Physician Service** means such services as are rendered by a licensed Physician within the scope of his license.
- 9.86 **Placement, or being placed, for adoption** means the assumption and retention of a legal obligation for total or partial support of a Child by a person with whom the Child has been placed in anticipation of the Child's adoption. The Child's Placement for adoption with such person terminates upon the termination of such legal obligation.
- 9.87 **Plain Film Radiograph** means a routine film x-ray performed in a Specialty Care Physician's office and provided in accordance with Coverage Policy established by the Company.
- 9.88 **Plan** means the Employee Health Benefit Plan established by your Employer. The terms of the Plan are set forth in the Group Policy or Group Insurance Contract between the Company and your Employer.
- 9.89 **Plan Administrator** means the Employer.
- 9.90 **Plan Year** means the Plan Year stated in the Employee Health Benefit Plan Summary Plan Description, or if not stated in that document, or if that document does not exist, the twelve-month period ending on the day before the anniversary date of the effective date of this Benefit Certificate.
- 9.91 **Policy** means the Group Policy or Group Insurance Contract.
- 9.92 **Policy Month** means a month commencing on the first day of a calendar month and expiring on the last day of that calendar month or commencing on the fifteenth day of a month and expiring on the fourteenth day of the following month, depending upon the billing cycle applied by the Company.
- 9.93 **Policyholder** means the Employer that established and maintains the Plan, as shown in the Application of the Group Insurance Policy.
- 9.94 **Preferred Provider** means a Contracting Provider who has agreed to participate in the Preferred Provider Organization and meets all applicable credentialing and contractual standards associated with the Preferred Provider Organization.
- 9.95 **Preferred Provider Organization** means a panel of Providers (Hospitals and Physicians) who have agreed to accept reimbursement for their services covered under this Plan at reduced charges.
- 9.96 **Prescription** means an order for Medications by a Physician or health care Provider authorized by applicable law to issue a Prescription, to a pharmacy for the benefit of and use by a Covered Person.
- 9.97 **Prescription Medication** or **Medication** means any pharmaceutical that has been approved by the FDA and can be obtained only through a Prescription. The Company has classified selected Prescription Medications, primarily Medications intended for self-administration as "A Medications." The Company has classified Intramuscular injections, Intravenous injections and other pharmaceuticals that are primarily intended for professional administration as "B Medications." You can determine whether a Medication is an A Medication or a B Medication by contacting Customer Service.
- 9.98 **Primary Care Physician** means a Preferred Provider Physician who provides primary medical care in one of these medical specialties: General Practice, Pediatrics, Family Practice, Obstetrics/Gynecology (when providing Preventive Health Services) or Internal Medicine. This also includes advanced practice nurses or physician's assistants who provide primary medical care in these medical specialties and are performed in the Primary Care Physician's office.
- 9.99 **Prior Approval** means the process initiated by the Company as a result of a pre-service claim (see Subsection 7.1.3.b.) to determine in advance of the Covered Person obtaining a requested medical service, Medication, supply, test, or equipment if such medical service, Medication, supply, test, or equipment initially meets Primary Coverage Criteria requirements set out in Subsection 2.4.1.b., e., or f., and is not subject to a Specified Plan Exclusion (see Section 4.0). Ongoing therapy of a prior authorized Medication may require periodic assessments that could include an efficacy measure intended to demonstrate positive outcomes for continuation of therapy. Plan benefits requiring the submission of a pre-service claim are described more fully below. **Failure of the Covered Person's treating Provider to obtain Prior Approval with respect to a pre-service claim will result in a denial of coverage but in all such instances involving a Contracting Provider who is contracted with the Company for participation in the Company's networks in Arkansas, the Covered Person shall have no payment obligation to such Contracting Provider, whose**

network contract requires waiver of provider charges for failure to obtain Prior Approval. In addition, if a Non-Contracting Provider or nonparticipating provider, in any state, pursues recovery of any amounts alleged to be due or payable under this Benefit Certificate with regard to services subject to Prior Approval, failure of such Non-Contracting Provider or nonparticipating provider to obtain Prior Approval with respect to a pre-service claim will result in a denial of coverage but in all such instances, a Non-Contracting Provider or a nonparticipating provider who requires or takes an assignment of benefits from the Covered Person or their authorized representative shall, by doing so, relieve the Covered Person from any payment obligations to such Non-Contracting Provider or nonparticipating provider, and the assignment shall be deemed to have waived all associated charges with respect to any such pre-service claim. Pre-service claims for services obtained outside of Arkansas from BlueCard participating providers are subject to the same Prior Approval requirements and any such claims lacking a required Prior Approval will be denied; however, whether the BlueCard participating provider's charges in such instances are waived when Prior Approval is not obtained by the BlueCard participating provider will depend, in each instance, on the terms of each Host Blue Plan's network participation agreement for the applicable BlueCard participating provider. PLEASE NOTE: Prior Approval does not mean that the service, supply or treatment will be covered regardless of other terms, conditions or limitations outlined in this Benefit Certificate, but means only that the information furnished to the Company in the pre-service claim indicates that the requested medical service, Medication, supply, test or equipment meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations, and coverage for these services may still be limited or denied if, when the post-service claim for the services is received by the Company, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Covered Person ceased to be eligible for benefits on the date the services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Benefit Certificate. For more information about Prior Approval, please see Subsection 7.3.1b.

Plan benefits requiring pre-service claims are claims for certain Prescription Medications (Subsection 3.24) and Non-PPO Benefits (Subsection 5.1.3).

- 9.100 **Prosthetic Device** means a device used to replace, correct, or support a missing portion of the body, to prevent or correct a physical deformity or malfunction, or to support a weak or deformed portion of the body. These devices include prosthetic devices for athletics, recreation, showering or bathing when deemed as medically necessary by treating physician. Prosthetic Devices do not include dentures or other dental appliances that replace either teeth or structures directly supporting the teeth.
- 9.101 **Prosthodontic Services** means Dental Care services for the diagnosis, treatment planning and rehabilitation of the oral function and health of patients with clinical conditions associated with missing or deficient teeth or oral and maxillofacial tissues, or both, using biocompatible substitutes. All Prosthodontic Services are paid as dental benefits.
- 9.102 **Provider** means an advance practice nurse; an athletic trainer; an audiologist; a certified orthotist; a chiropractor; a community mental health center or clinic; a dentist, a Hospital; a licensed ambulatory surgery center; a licensed certified social worker; a licensed dietician; a licensed durable medical equipment provider; a licensed professional counselor; a licensed psychological examiner; a long-term care facility; a non-Hospital based medical facility providing clinical diagnostic services for sleep disorders; a non-Hospital based medical facility providing magnetic resonance imagining, computed axial tomography, or other imaging diagnostic testing; an occupational therapist; an optometrist; a pharmacist; a physical therapist; a physician or surgeon (M.D. and D.O.); a podiatrist; a prosthetist; a psychologist; a respiratory therapist; a rural health clinic; a speech pathologist and any other type of health care Provider which the Company, in its sole discretion, approves for reimbursement for services rendered.
- 9.103 **Psychiatric Residential Treatment Center** means a facility, or a distinct part of a facility, for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

- 9.104 **Qualified Employee** means an individual employed by a qualified employer who has been offered health insurance coverage by such qualified employer through the Small Health Options Program (“SHOP”).
- 9.105 **Qualified Employer** means a small employer that elects to make, at a minimum, all full-time employees of such employer eligible for a QHP in the small group market offered through the SHOP
- 9.106 **Qualified Health Plan or QHP** means a health plan that has in effect a certification issued by the Exchange.
- 9.107 **Recognized Amount** is the amount which your cost sharing is based on for the following Covered Services when provided by Out-of-Network Providers: Out-of-Network Emergency Care; non-Emergency Care received at certain In-Network facilities by Out-of-Network Providers, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, "certain In-Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary. The Recognized Amount is based on the qualifying payment amount as determined under applicable law.
- Note: Covered Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Services were determined based upon an Allowed Amount.**
- 9.108 **Relevant to the Claim** means a document, record or other information that:
1. was relied upon in making the benefit determination;
 2. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
 3. demonstrates compliance with the administrative processes and safeguards required by 7.2.5.b.; and
 4. constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Covered Person’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
- 9.109 **Routine Patient Costs** in connection with an Approved Clinical Trial mean the costs for health interventions covered by the Plan except:
1. the investigational item, device or service, itself;
 2. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management of the individual undergoing the clinical trial; or
 3. a service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.
- 9.110 **Routine Prenatal Care** means outpatient antepartum care and laboratory testing that has been approved as routine based on a Coverage Policy established by the Company. A copy of the Routine Prenatal Care Coverage Policy is available from the Company, at no cost, upon request, or may be reviewed on the Company’s web site at WWW.ARKANSASBLUECROSS.COM.
- 9.111 **Severe Traumatic Brain Injury** means a sudden trauma causing damage to the brain as a result of the head suddenly and violently hitting an object or an object piercing the skull and entering brain tissue with an extended period of unconsciousness or amnesia after the injury or a Glasgow Coma Scale below 9 within the first 48 hours of injury.
- 9.112 **Skilled Nursing Facility** means an institution licensed as such by the appropriate state agency. A Skilled Nursing Facility must:
1. be operated pursuant to law;
 2. be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

3. be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed Physician (M.D. or D.O.);
4. provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.) for at least 8 hours per day and a registered graduate professional nurse (R.N.) or licensed practical nurse (L.P.N.) for the remaining 16 hours; and
5. maintain a daily medical record of each patient.

However, a Skilled Nursing Facility does not include:

1. any home, facility or part thereof used primarily for rest;
2. a home or facility for the aged or for the care of drug addicts or alcoholics; or
3. a home or facility primarily used for the care and treatment of mental diseases, or disorders, or Custodial Care or educational care.

- 9.113 **Specialty Care Physician** means a Preferred Provider Physician with any specialty other than primary care who practices such specialty and who has met the participation standards of the Company. (Specialty Care Physicians do not include the following: Family Practice, General Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology – when providing Preventive Health Services.)
- 9.114 **Spouse** means an individual who is the husband or wife of an Employee as a result of a marriage that is legally recognized in a jurisdiction within the United States of America.
- 9.115 **Step Therapy** means a process that establishes a required order of use for a specific Prescription Medication. For example, a Step Therapy may require that medication “X” be used for a period of time before medication “Y” or that a weaker strength of a medication be used for a period before a stronger strength of the same medication.
- 9.116 **Stepchild** means a natural or adopted Child of the Spouse of the Employee.
- 9.117 **Substance Use Disorder** means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.
- 9.118 **Substance Use Disorder Residential Treatment Center** means a facility that provides treatment for substance (alcohol and drug) use disorders to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drug and supplies, psychological testing, and room and board.
- 9.119 **Telemedicine** means the use of information and communication technology to deliver healthcare services, including without limitation to the assessment, diagnosis, consultation, treatment, education, care management, and self-management. Telemedicine includes store-and-forward technology and remote patient monitoring **but does not include** audio-only communication unless it is real-time, interactive and substantially meets the requirements for a Covered Service that would otherwise be covered by the Plan, including without limitation a facsimile machine, text messaging, or electronic mail systems.
- 9.120 **Therapeutic care** means services provided by licensed speech-language pathologists, occupational therapists, or physical therapists for the treatment of autism spectrum disorders as ordered by a Physician
- 9.121 **Transplant Global Period** means a period of time that begins on or prior to the day of the transplant procedure and extends for a number of days after the transplant procedure. The length of the Transplant Global Period varies, depending upon the type of transplant involved.
- 9.122 **Waiting Period** means the time beginning with the Employee's most recent date of continuous employment with the Employer and ending on the date he is eligible for insurance. The Employer establishes the Waiting Period, but for purposes of coverage or eligibility determinations under this Benefit Certificate, the Waiting Period shall be such period as is reflected in the enrollment records of the Company.
- 9.123 **We, Our and Us** mean the Company.
- 9.124 **Work Hardening** means a highly specialized rehabilitation program that spans the transition from traditional rehabilitation therapies to return to work by simulating the workplace activities and surroundings in a monitored environment. Programs may be developed and carried out by an occupational therapist and/or

physical therapist. The goal is to create an environment in which returning workers can rebuild psychological self-confidence and physical reconditioning by replicating their work routine.

9.125 **Work Integration (Community)** means training in shopping, transportation, money management, vocational activities and/or work environment/modification analysis, and/or work task analysis. This is not considered medical treatment.

9.126 **You and Your** mean a Covered Person.

10.0 YOUR RIGHTS UNDER ERISA

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). This information and the information contained in this Benefit Certificate, constitute the Summary Plan Description required by ERISA.

10.1 **Information about the Plan** As a participant in the Plan described in this Benefit Certificate, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office all plan documents, including insurance company contracts, and copies of all documents filed by the plan with the U.S. Department of Labor such as detailed annual reports and plan descriptions.
2. Obtain copies of all applicable plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.
3. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

10.2 **Continuation of Coverage.** The Plan provides an opportunity to continue coverage for yourself, spouse, dependents if there is a loss of coverage under the Plan as a result of a qualifying event. See Subsection 6.4.3.a. You or your dependents may have to pay for such coverage. Review this Benefit Certificate, Subsection 6.4.3 and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

10.3 **Creditable Coverage** The Plan provides a reduction or elimination of exclusionary periods of coverage for Preexisting Conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it up to 24 months after losing coverage. You may also request a certificate of creditable coverage at any time during your coverage period by writing Arkansas Blue Cross and Blue Shield, Customer Service Division, Post Office Box 2181 Little Rock, Arkansas 72203, or by Telephone to (501) 378-2070 or toll free (800) 421-1112. Without evidence of creditable coverage, you may be subject to Preexisting Condition exclusion for 12 months after your enrollment in your coverage.

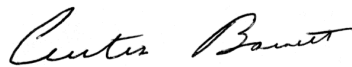
10.4 **Prudent Actions by Plan Fiduciaries**

1. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries.
2. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in a way to prevent you from obtaining a benefit or exercising your rights under ERISA.

10.5 **Enforce your Rights**

1. If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

2. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees for example, if it finds your claim is frivolous.
- 10.6 **Assistance with Your Questions** If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.
- 10.7 **Claim and Appeal Procedures** The Plan rules and procedures for filing claims and seeking review of adverse claim determinations are set forth in Section 7.0 of this Benefit Certificate.



Curtis Barnett, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
Little Rock, Arkansas 72201

ARKANSAS CONSUMERS INFORMATION NOTICE

For additional information regarding your Arkansas Blue Cross and Blue Shield benefits, please feel free to contact us at:

Arkansas Blue Cross and Blue Shield
Customer Service
Post Office Box 2181
Little Rock, Arkansas 72203
Telephone toll free (800) 238-8379

If we at Arkansas Blue Cross and Blue Shield fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202
Telephone (501) 371-2640 or toll free (800) 852-5494
insurance.consumers@arkansas.gov.

**LIMITATIONS AND EXCLUSIONS UNDER THE
ARKANSAS LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy and contract owners who live in this state and, in some cases, to keep coverage in force. Please note that the valuable extra protection provided by the member insurers through the Guaranty Association is limited. This protection is not a substitute for a consumers' careful consideration in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") provides coverage of claims under some types of policies or contracts if the insurer or health maintenance organization becomes impaired or insolvent. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.** Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in the State of Arkansas. Other conditions may also preclude coverage.

The Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer or health maintenance organization and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy or health maintenance organization coverage.

You should not rely on availability of coverage under the Guaranty Association when selecting an insurer or health maintenance organization.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, Arkansas 72201

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

The state law that provides for this safety net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"), which is codified at Ark. Code Ann. §§ 23-96-101, *et seq.* Below is a brief summary of the Act's coverage, exclusions and limits. This summary does not cover all provisions of the Act, nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state; or
- Their policy or contract was issued by a hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends, voting rights, and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employer plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);
- Unallocated annuity contracts issued to or in connection with benefit plans protected under the Federal Pension Benefit Corporation ("FPBC"), regardless of whether the FPBC is yet liable;
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by state or federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, claims for policy misrepresentations, and extra-contractual or penalty claims; or
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustee(s).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 in life insurance death benefits without regard to the number of policies and contracts there were with the same company, even if they provided different types of coverages. The Guaranty Association will pay a maximum of \$500,000 in health benefits, provided that coverage for disability insurance benefits and long-term care insurance benefits shall not exceed \$300,000. The Guaranty Association will pay \$300,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits. These are limitations under which the Guaranty Association is obligated to operate prior to considering either its subrogation and assignment rights or the extent to which those benefits could be provided from assets of the impaired or insolvent insurer.